# **Table of Contents**

**State/Territory Name: Arizona** 

State Plan Amendment (SPA) #: 13-0005-MM

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages
- 4) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services San Francisco Regional Office 90 Seventh Street, Suite 5-300 (5W) San Francisco, CA 94103-6706



### DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 30, 2013

Tom Betlach, Director Arizona Health Care Cost Containment System 801 East Jefferson Street Phoenix, AZ 85034

Dear Mr. Betlach:

Enclosed is an approved copy of Arizona's state plan amendment (SPA) 13-0005-MM, which was submitted to CMS on July 8, 2013. SPA 13-0005-MM incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Arizona's Medicaid State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0005-MM includes full approval of your alternative single streamlined application – both the paper and online versions.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the back of Arizona's approved state plan:

- S94, pages 1-2
- Attachment 1 Alternative single, streamlined paper application: Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)/Arizona Health Care Cost Containment System (AHCCCS Application for Help with Health Coverage Costs, AH-001 (10/13)
- Attachment 2 An alternative paper application for multiple human service programs, including health insurance, SNAP and TANF: Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)/Arizona Health Care Cost Containment System (AHCCCS) Combined Application for Benefits, FA-001 (10/13)
- Attachment 3 Health-e-Arizona Plus Medical Application Roadmap
- Attachment 4 Health-e-Arizona Plus Online Flow Chart
- Attachment 5 Key Differences between the Health–e-Arizona Plus online application and the CMS online application
- Attachment 6 Statement regarding Agreements Related to Coordination of Eligibility and Enrollment

In addition, the following current state plan pages have been superseded by SPA 13-0005-MM and reserved in the State Plan:

- Section 2, Page 10, section 2.1(a), TN # 92-4, effective date: 1/1/92, approved: 6/2/92
- Section 2, Page 11a, section 2.1(d), TN # 92-4, effective date: 1/1/92, approved: 6/2/92

Please note that the HHS Office for Civil Rights (OCR) has an open civil rights investigation in Arizona to resolve complaints filed under Title VI of the Civil Rights Act. During the course of its investigation, OCR has identified compliance concerns with Arizona's Medicaid forms and procedures for processing Medicaid applications. CMS' review of Arizona's State Plan amendment and proposed forms, in lieu of using the CMS Model Single Streamlined Application, was limited to an analysis of compliance with applicable Medicaid laws and regulations. Because compliance with Federal civil rights laws is also a condition of receipt of Medicaid funding, however, HHS OCR also reviewed Arizona's forms in the context of its Title VI investigation and we sent comments to the state on behalf of OCR on August 9, 2013. HHS OCR officials met with Arizona State officials to discuss resolution measures on August 12, 2013 and CMS is happy to provide technical assistance about Medicaid issues during the course of any subsequent discussions. Both CMS and HHS OCR are committed to working together with Arizona to meet the deadlines under the Affordable Care Act to assist the State of Arizona in being ready to launch Marketplace options in a way that ensures that both Medicaid and civil rights issues are addressed.

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan amendment. If you have any questions concerning this SPA, please contact Rebecca Bruno at 415-744-3677, or by e-mail at Rebecca.Bruno@cms.hhs.gov.

Sincerely,

/s/

Gloria Nagle, Ph.D., MPA Associate Regional Administrator Division of Medicaid & Children's Health Operations

cc: Wakina Scott HeeYoung Ansell

# Medicaid State Plan Eligibility: Summary Page (CMS 179) State/Territory name: Arizona Transmittal Number: Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered. AZ-13-0005 **Proposed Effective Date** 10/01/2013 (mm/dd/yyyy) Federal Statute/Regulation Citation 42 CFR 435, Subpart J and Subpart M Federal Budget Impact Federal Fiscal Year Amount \$ 96550800.00 First Year 125606400.00 Second Year Subject of Amendment Arizona State Plan Amendment to include the General Eligiblity Requirements; Eligibility Process S94 information in the State Plan. Governor's Office Review Governor's office reported no comment Comments of Governor's office received Describe: No reply received within 45 days of submittal Other, as specified Describe: Governor's Office is aware.

Theresa Gonzales

Sep 30, 2013

Signature of State Agency Official

Submitted By:

Date Submitted:

DATE RECEIVED:	DATE APPROVED:
7/8/2013	9/30/2013
PLAN APPROVED - ON	E COPY ATTACHED
EFFECTIVE DATE OF APPROVED MATERIAL:	SIGNATURE OF REGIONAL OFFICIAL:
10/1/2013	
TYPED NAME	TITLE
Gloria Nagle	Associate Regional Administrator

SO B



# **Medicaid Eligibility**

OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

General Eligibility Requirements Ligibility Process
2 CFR 435, Subpart J and Subpart M
ligibility Process
The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.
Application Processing
Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.
The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.
An attachment is submitted:
An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.
An attachment is submitted.
Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:
The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.
An attachment is submitted.
An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.
An attachment is submitted.
The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.
The agency also accepts applications by other electronic means:
• Yes O No

Arizona



# **Medicaid Eligibility**

	Indicate the other electronic means below:		
	Name of Method	Description	
	Fax	An individual can fax an application to the Medicaid or Human Services Agency	X
V		icants and perform initial processing of applications for the eligine receipt and processing of applications for the title IV-A programmer in the contract of	
	Parents and Other Caretaker Relatives		
	Pregnant Women		
	Infants and Children under Age 19		
Re	determination Processing		
V	Redeterminations of eligibility for individuals whose finan- income standard are performed as follows, consistent with	cial eligibility is based on the applicable modified adjusted gross 42 CFR 435.916:	s
	Once every 12 months		
	Without requiring information from the individual if at account or other more current information available to	ole to do so based on reliable information contained in the indivi the agency	dual's
		basis of the information available to it, or otherwise needs addit s the individual with a pre-populated renewal form containing the	
	Redeterminations of eligibility for individuals whose finan- income standard are performed, consistent with 42 CFR 43	cial eligibility is not based on the applicable modified adjusted g 5.916 (check all that apply):	gross
	☑ Once every 12 months		
	Once every 6 months		
	Other, more often than once every 12 months		
Co	ordination of Eligibility and Enrollment		
<b>V</b>		rt M relative to coordination of eligibility and enrollment betwee ity programs. The single state agency has entered into agreement insurance affordability programs.	

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

Arizona

OMB No.: 0938-

Revision: HCFA-PM-91-4 (BPD)

August 1991

State: Arizona

Reserved

TN No.: 13-0005-MM Supersedes Approval Date September 30, 2013 Effective Date October 1, 2013

TN No.: 92-4

OMB No.

Revision: HCFA-PM-91-8 (MB)

October 1991

State/Territory: Arizona

Reserved

TN No. 13-0005-MM Supersedes

TN No. 92-4

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA) Arizona Health Care Cost Containment System (AHCCCS)

# Application for Help with Health Coverage Costs

AHCCCS Medical Assistance, Help with Medicare Costs, and Tax Credits to help pay premiums

Tear off and I	keep pages A	through D for	vour records.

# What is this application for?

Use this application to see if you and your family qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- A new tax credit that can help pay your health insurance premiums

# Who can use this application?

An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your family members. You can use this application to apply for anyone in your family, even if they already have insurance.

#### Your family includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance)
- People you claim on your income tax return even if they do not live with
- Relatives in your care who are under the age of 19 and live with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application.

# Where else can I apply?

You can apply faster online at: www.healthearizonaplus.gov

You can fill out this application and turn it in by mail, fax or in person to any local or any Department of Economic Security (DES)/Family Assistance Administration (FAA) office. You can find a list of local FAA offices at www.azdes.gov/faa, or you can call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

# What information do I need to complete this application?

### You may need:

- Birth dates
- Social Security numbers
- Employer and income information for everyone in your family
- Information for any current health insurance
- Information about any job-related health insurance available to your family

# Why do we ask for so much information?

We ask about income and other information to make sure you and your family get the correct benefits.

# What happens next?

### We will keep all information you provide private, as required by law.

Send your completed, signed application to the address on page 14 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

What if I need help?

If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov Phone: 1-855-HEA-PLUS (432-7587)

Effective Date: October 1, 2013

In person: Visit www.azdes.gov/faa or call 1-855-HEA-PLUS (432-7587) to find the office closest to you

### What is AHCCCS Medical Assistance?

AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona's Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Anzona residents who meet certain income and other eligibility standards.

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication\*
- Doctor's Office Visits\*\*
- Laboratory and X-ray Services
- Hospital Services
- Dialysis

- Medical Supplies
- Medically Necessary Transportation
- Medically Necessary Specialist Care
- Behavioral Health Care
- Immunizations (shots) \* AHCCCS prescription coverage is limited for people who have Medicare.

- Chemotherapy
- · Emergency Medical Care
- Rehabilitation Services
- · 90 days of nursing care services

### What is Medicare Savings Program?

\*\* Wellness visits for people age 21 and over are not covered.

Medicare Savings Program may pay:

- · Medicare Part A premium
- Medicare Part B premium

- · Medicare deductibles and copayments
- · Automatic Extra Help for Medicare Part D prescription expenses

### What if I am not eligible for AHCCCS Medical Assistance?

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

### Do I need a Social Security number?

Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance or help with Medicare costs (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

- If you or anyone you are applying for does not have a Social Security number (SSN), we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

We use your information, including Social Security number, to:

- · Verify identity
- Verity citizenship and immigration status
- Verify income
- · Prevent duplicate benefits
- · Collect money we overpaid you in the form of benefits
- Computer match with state, local and federal agencies and our other programs to verify information
- Share with other government agencies and their contractors to assess program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

### Do I have to give information about my citizenship and immigration status?

- To get the most AHCCCES Medical Assistance benefits and/or help with Medicare costs, you need to give us information about citizenship and immigration status for each person who is applying for help.
- If you choose not give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying for AHCCCS Medical Assistance and/or help with Medicare costs.
- You do need to give us information on income, resources, or other information for those who have not given us citizenship or immigration status information to complete the application process.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for medical benefits. For those non-citizens, United States Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.
- If you are not applying for benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS. We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family or a
- household member is in the U.S. illegally.

### How long does it take to find out if I qualify for benefits after you receive my application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 20 days if you are pregnant. If you need a disability determination report, we will make a decision within 90 days. For all other applicants, we will make a decision within 45 days.

### How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

- You are American Indian and you choose American Indian Health Program as your health plan.
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

### How does a health plan work?

The health plan works with the health care providers (doctors, hospitals, pharmacies, etc.) to provide all AHCCCS covered services. The health plan will send you a member handbook once you are enrolled. You can call the health plan if you have any questions about your benefits or services or if you need interpreter services or an accommodation because of a disability. The telephone number for your health plan's member or customer service can be found on your AHCCCS ID card and in your Member Handbook.

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### What is a primary doctor?

After you enroll in a health plan, your health plan will give you a list of primary doctors in your area to choose from. If you do not choose a primary doctor one will be assigned to you. You have the right to change your primary doctor at any time by calling your health plan's Member Services. Your primary doctor will:

- · Take care of your health care
- · Be the first person you go to for non-emergency medical services
- · Send you to a specialist when needed

### How do I get behavioral health services?

To get behavioral health services you can go through your primary doctor, or call the behavioral health telephone number on your AHCCCS ID card.

#### What if I have Medicare or other health insurance?

- Be sure to tell your health plan that you have Medicare or any other health insurance.
- If your doctor does not contract with your AHCCCS health plan, your doctor must call the AHCCCS health plan to coordinate care or you may be responsible
  for any Medicare or other health insurance co-payments or deductibles.
- . If you are in an HMO, you should pick a primary doctor who works with both your HMO and your AHCCCS health plans.
- If you have Medicare, your prescription coverage under AHCCCS is limited. If you have questions about prescriptions, call 1-800-MEDICARE (1-800-633-4227) or your AHCCCS health plan.

#### What is an AHCCCS ID card and what do I do with it?

Your AHCCCS ID card has your unique AHCCCS ID number.

- Show the card when you get medical care. You may also need to show picture ID.
- . Doctors, hospitals and pharmacists use your AHCCCS ID card to obtain faster verification of eligibility.
- · Keep your AHCCCS ID card with you at all times.
- Do not let anyone else use your AHCCCS ID card or you may be prosecuted.

### What does AHCCCS Medical Assistance cost?

#### Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are \$10 to \$35 per person for employed people with disabilities.

#### Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- \$2.30 to \$10.00 for prescriptions
- \$0.00 to \$30.00 for non-emergency use of an emergency room
- \$3.40 to \$5.00 for outpatient visits for evaluation and management services including doctors office visits
- \$2.30 to \$3.00 for physical, occupational or speech therapy

Remember to report any changes in income because this may change your co-payment amount.

#### The following people are never asked to pay co-payments:

- · Children under age 19.
- · People determined to be Seriously Mentally III (SMI) by the Arizona Department of Health Services.
- · Individuals through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program.
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's
  medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year.
- · People who receive hospice care.

#### Co-payments are never charged for the following services for anyone:

Hospitalizations

- Emergency services
- Services paid for on a fee-for-service basis
- Family planning services and supplies
- Pregnancy related health care including tobacco cessation for pregnant women

### What are my rights and responsibilities?

#### You have the RIGHT to:

- · Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- · Apply for AHCCCS Medical Assistance and/or help with Medicare costs and be given a letter that tells you if you are eligible or not.
- Review DES and/or AHCCCS manuals that show the rules and regulations of the DES and/or AHCCCS program if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- · Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or your DES and/or AHCCCS services being reduced, or if a
  decision is not made on your application within 45 days and the delay is due to DES or AHCCCS.
- · Look at your file before a fair hearing.
- · Bring an attorney or any other person to a fair hearing.

### You have the RESPONSIBILITY to:

- Provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information which pertains to eligibility.
- Give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.
- Take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to Social Security benefits. Railroad retirement, Veterans benefits and unemployment compensation.
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report changes timely.

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

AH-001 (10/13) Arizona Page C

### How to Choose an AHCCCS Health Care Plan:

You need to choose a health plan that services your county.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS Health Plan.
- Before you choose a plan, check with your doctor, pharmacy or hospital, to see if they work with the plan that you want. If you want more information about the doctors, specialists or hospitals that work with a health plan that serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application. This health plan choice does not affect your plan selection through the federal Health Insurance Marketplace.

ADAQUE COUNTY	MOHAVE COUNTY
APACHE COUNTY	
UnitedHealthcare Community Plan1-800-348-4058	UnitedHealthcare Community Plan1-800-348-4058
Health Choice Arizona1-800-322-8670	Health Choice Arizona1-800-322-8670
American Indian Health Program928-729-8000	American Indian Health Program928-769-2900
If your zip code is 85943, you must choose from the health	If your zip code is 86434, you must choose from the health
plans listed under Navajo County.	plans listed under Yavapai County.
COCHISE COUNTY	NAVAJO COUNTY
University Family Care1-800-582-8686	UnitedHealthcare Community Plan1-800-348-4058
UnitedHealthcare Community Plan 1-800-348-4058	Health Choice Arizona1-800-322-8670
American Indian Health Program 520-295-2479	American Indian Health Program928-338-4911
COCONINO COUNTY	DIMA COUNTY
COCONINO COUNTY	PIMA COUNTY UnitedHealthcare Community Plan1-800-348-4058
UnitedHealthcare Community Plan 1-800-348-4058	Health Choice Arizona1-800-322-8670
Health Choice Arizona1-800-322-8670	Health Choice Arizona1-800-322-8670
American Indian Health Program 928-283-2501	Care 1 <sup>st</sup> Arizona1-866-560-4042
	University Family Care1-800-582-8686
If your zip code is 86336 or 86340, you must choose from	Mercy Care Plan1-800-624-3879
the health plans listed under Yavapai County.	American Indian Health Program520-295-2479
GILA COUNTY	If your zip code is 85645, you must choose from the health
Health Choice Arizona 1-800-322-8670	plans listed under Santa Cruz County.
University Family Care1-800-582-8686	
American Indian Health Program 928-475-2371	PINAL COUNTY
<b>3</b>	Health Choice Arizona1-800-322-8670
GRAHAM COUNTY	University Family Care1-800-582-8686
University Family Care1-800-582-8686	American Indian Health Program520-562-3321
UnitedHealthcare Community Plan 1-800-348-4058	<b>.</b>
American Indian Health Program	If your zip code is 85242 or 85220, you must choose from
American malan rioditi riogram	the health plans listed under Maricopa County.
If your zip code is 85643, you must choose from the health plans	,
listed under Cochise County.	If your zip code is 85292 you must choose from the health
noted artaer coeffice county.	plans listed under Gila County.
GREENLEE COUNTY	
University Family Care 1-800-582-8686	SANTA CRUZ COUNTY
UnitedHealthcare Community Plan 1-800-348-4058	University Family Care1-800-582-8686
American Indian Health Program 928-475-2371	UnitedHealthcare Community Plan1-800-348-4058
	American Indian Health Service520-295-2479
LA PAZ COUNTY	
UnitedHealthcare Community Plan 1-800-348-4058	YAVAPAI COUNTY
University Family Care 1-800-582-8686	UnitedHealthcare Community Plan1-800-348-4058
American Indian Health Program928-669-2137	University Family Care1-800-582-8686
	American Indian Health Program602-263-1200
MARICOPA COUNTY	
Health Net of Arizona 1-888-788-4408	If your zip code is 85342, 85358 or 85390, you must
Care 1 <sup>st</sup> Arizona 1-866-560-4042	choose from the health plans listed under Maricopa
Health Choice Arizona1-800-322-8670	County.
UnitedHealthcare Community Plan 1-800-348-4058	
Mercy Care Plan1-800-624-3879	If your zip code is 86351 you must choose from the health
Maricopa Health Plan	plans listed under Coconino County.
American Indian Health Program 602-263-1200	
•	YUMA COUNTY
	UnitedHealthcare Community Plan1-800-348-4058
	University Early Care 1-800-582-8686

MOHAVE COUNTY UnitedHealthcare Community Plan1-800-348-4058 Health Choice Arizona
If your zip code is 86434, you must choose from the health plans listed under Yavapai County.
NAVAJO COUNTY UnitedHealthcare Community Plan1-800-348-4058 Health Choice Arizona1-800-322-8670 American Indian Health Program928-338-4911
PIMA COUNTY           UnitedHealthcare Community Plan         1-800-348-4058           Health Choice Arizona         1-800-322-8670           Care 1 <sup>st</sup> Arizona         1-866-560-4042           University Family Care         1-800-582-8686           Mercy Care Plan         1-800-624-3879           American Indian Health Program         520-295-2479
If your zip code is 85645, you must choose from the health plans listed under Santa Cruz County.
PINAL COUNTY Health Choice Arizona
If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.
If your zip code is 85292 you must choose from the health plans listed under Gila County.
SANTA CRUZ COUNTY University Family Care
YAVAPAI COUNTY UnitedHealthcare Community Plan1-800-348-4058 University Family Care1-800-582-8686 American Indian Health Program602-263-1200
If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.

University Family Care.....1-800-582-8686 American Indian Health Program......760-572-4100

Approval Date: September 30, 2013 Effective Date: October 1, 2013 Transmittal Number: AZ 13-0005-MM

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

# **Application for Help with Health Coverage Costs**

Contact Information:		
Tell us how we can contact an adult member of your family		
Name (First, Middle, Last):		***************************************
Home Address:	Apt. # City: State: Zip Code:	
	Apt. # City: State: Zip Code:	
Phone Number: This n		
Other Phone Number: This r	umber is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other:	
	English	
	English    Spanish    Other:	
I would like to get information about this application by: Email:  Yes  No Email address: Text: Yes  No Number to text (standard text rest)	ates apply):	
•	on for this application will be sent via U.S. Mail to the mailing address provided.	
I need the following help with this application (check all that		
☐ Reading/understanding this application ☐ Fill	ing out this application    Other:	
☐ American Sign Language ☐ Bra	ille	
I need the following accommodations for this application (cl ☐ Hearing ☐ Speaking ☐ Seeing ☐ W	neck all that apply): /riting	
Tribaing Topouring Tooling Tr	nung C training C outon.	
Authorized Representative:		
	se to represent you. AHCCCS cannot release any information about your	
eligibility without your written consent.		
Poprocontativo's Name:	Organization (if applicable):	
nepresentative s Name.	Organization (if applicable):	
Representative's Mailing Address:	City: State: Zip Code:	
Representative's Mailing Address:	City: State: Zip Code: This number is: Home Cell Work Message Other:	
Representative's Mailing Address:	City: State: Zip Code:  This number is:  Home Cell Work Message Other:  This number is:  Home Cell Work Message Other:	
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?	City: State: Zip Code: This number is: Home Cell Work Message Other: Denglish Spanish Other:	
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?	City: State: Zip Code: This number is: Home Cell Work Message Other: State: Sta	
Representative's Mailing Address:	City: State: Zip Code: This number is: □ Home □ Cell □ Work □ Message □ Other: This number is: □ Home □ Cell □ Work □ Message □ Other: □ English □ Spanish □ Other: Pplication by:	
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language  My representative would like to get information about this a  Email:  Yes  No  No  Number to text (standard text ra	City: State: Zip Code: This number is: □ Home □ Cell □ Work □ Message □ Other: This number is: □ Home □ Cell □ Work □ Message □ Other: □ English □ Spanish □ Other: Pplication by:  tes apply):	
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language  My representative would like to get information about this a  Email:  Yes  No Email address:  Text:  Yes  No Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati  By signing below i, the customer, give permission for the person listed	City: State: Zip Code: This number is: □ Home □ Cell □ Work □ Message □ Other: This number is: □ Home □ Cell □ Work □ Message □ Other: □ English □ Spanish □ Other: Pplication by:  tes apply): on for this application will be sent via U.S. Mail to the mailing address provided.  above □ By signing below I, the representative, agree to act on the customer's behalf. Lai	
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language  My representative would like to get information about this a  Email:  Yes  No  Number to text (standard text ra  If "Yes" is not marked for Email or Text, all information	City: State: Zip Code: This number is:	
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes No Email address:  Text: Yes No Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati  By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m  AHCCCS Medical Assistance and/or Medicare Savings Program. I, th  Give permission for my representative to complete and sign my	City: State: Zip Code: This number is: Home Cell Work Message Other: This number is: Home Cell Work Message Other: English Spanish Other: Penglish Spanish Other: Pon for this application will be sent via U.S. Mail to the mailing address provided. By signing below I, the representative, agree to act on the customer's behalf. I also e for agree to: Provide only truthful and complete information under penalty of perjury. Fill in and sign needed forms.	So
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes  No  Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati  By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, the	City: State: Zip Code: This number is: _ Home _ Cell _ Work _ Message _ Other: This number is: _ Home _ Cell _ Work _ Message _ Other: English _ Spanish _ Other: Penglish _ Spanish _ Other:  tes apply): on for this application will be sent via U.S. Mail to the mailing address provided.  above e for erefore: _ Provide only truthful and complete information under penalty of perjury.  Fill in and sign needed forms.  Obtain and give to DES and/or AHCCCS all information needed to determine.	So
Representative's Mailing Address: Representative's Phone Number: Representative's Other Phone Number: What is the representative's preferred SPOKEN language? What is the representative's preferred WRITTEN language My representative would like to get information about this a Email: Yes No Email address: Text: Yes No Number to text (standard text ra If "Yes" is not marked for Email or Text, all informati By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, th Give permission for my representative to complete and sign my application. Give permission for my representative to provide any documents requested, including personal information.	City: State: Zip Code: This number is:	so ne if
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes  No  Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, th Give permission for my representative to complete and sign my application.  Give permission to my representative to provide any documents requested, including personal information.  Give permission to my representative to sign on my behalf to per other people, businesses, or agencies to give personal information.	City: State: Zip Code: This number is: _ Home _ Cell _ Work _ Message _ Other: This number is: _ Home _ Cell _ Work _ Message _ Other: English _ Spanish _ Other: Plication by:  Ites apply): In for this application will be sent via U.S. Mail to the mailing address provided.  By signing below I, the representative, agree to act on the customer's behalf. I aliangue to:  Provide only truthful and complete information under penalty of perjury.  Fill in and sign needed forms.  Obtain and give to DES and/or AHCCCS all information needed to determine the customer can qualify for AHCCCS Medical Assistance and/or Medicare Savings Program, such as the customer's Social Security number, income, citizenship, residency, medical insurance, and information about the customer.	so ne if
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email: Yes No Email address:  Text: Yes No Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati  By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m  AHCCCS Medical Assistance and/or Medicare Savings Program. I, th  Give permission for my representative to complete and sign my application.  Give permission for my representative to provide any documents requested, including personal information.  Give permission to my representative to sign on my behalf to per other people, businesses, or agencies to give personal informatic about me to DES and/or AHCCCS, including protected health	City: State: Zip Code: This number is: Home Cell Work Message Other: This number is: Home Cell Work Message Other:	so ne if
Representative's Mailing Address: Representative's Phone Number: Representative's Other Phone Number: What is the representative's preferred SPOKEN language? What is the representative's preferred WRITTEN language? My representative would like to get information about this a Email: Yes No Email address: Text: Yes No Number to text (standard text ra If "Yes" is not marked for Email or Text, all informati By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, th Give permission for my representative to complete and sign my application. Give permission for my representative to provide any documents requested, including personal information. Give permission to my representative to sign on my behalf to per other people, businesses, or agencies to give personal informatic about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled. Agree to give information about my personal circumstances to my	City: State: Zip Code: This number is: _ Home _ Cell _ Work _ Message _ Other: This number is: _ Home _ Cell _ Work _ Message _ Other: English _ Spanish _ Other: Plication by:  tes apply): on for this application will be sent via U.S. Mail to the mailing address provided.  above e for agree to:  Provide only truthful and complete information under penalty of perjury.  Fill in and sign needed forms.  Obtain and give to DES and/or AHCCCS all information needed to determin the customer can qualify for AHCCCS Medical Assistance and/or Medicare Savings Program, such as the customer's Social Security number, income, citizenship, residency, medical insurance, and information about the customer spouse, minor children, and parents (if the customer is a minor child).  Tell DES and/or AHCCCS right away if the customer:  Has a change in address; or	so ne if
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes No Email address:  Text:  Yes No Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, th  Give permission for my representative to complete and sign my application.  Give permission for my representative to provide any documents requested, including personal information.  Give permission to my representative to sign on my behalf to per other people, businesses, or agencies to give personal informatio about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.  Agree to give information about my personal circumstances to my representative.	City:	so ne if
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes No Email address:  Text:  Yes No Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, th  Give permission for my representative to complete and sign my application.  Give permission for my representative to provide any documents requested, including personal information.  Give permission to my representative to sign on my behalf to per other people, businesses, or agencies to give personal informatio about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.  Agree to give information about my personal circumstances to my representative.  Agree to allow my representative to assign all my rights to medica reimbursement claims to AHCCCS on my behalf.	City:	ne if
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes  No  Email address:  Text:  Yes  No  Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati  By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying my  AHCCCS Medical Assistance and/or Medicare Savings Program. I, the  Give permission for my representative to complete and sign my  application.  Give permission to my representative to provide any documents  requested, including personal information.  Give permission to my representative to sign on my behalf to per  other people, businesses, or agencies to give personal information  about me to DES and/or AHCCCS, including protected health  information needed to determine if I am disabled.  Agree to give information about my personal circumstances to my  representative.  Agree to allow my representative to assign all my rights to medica  reimbursement claims to AHCCCS on my behalf.  If I am determined eligible, this authorization will stay in effect until  assistance is withdrawn or denied, or when my eligibility ends. Ho	City:	ne if
Representative's Mailing Address: Representative's Phone Number: Representative's Other Phone Number: What is the representative's preferred SPOKEN language? What is the representative's preferred WRITTEN language My representative would like to get information about this a Email: Yes No Email address: Text: Yes No Number to text (standard text ra If "Yes" is not marked for Email or Text, all informati By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying m AHCCCS Medical Assistance and/or Medicare Savings Program. I, th Give permission for my representative to complete and sign my application. Give permission for my representative to provide any documents requested, including personal information. Give permission to my representative to sign on my behalf to per other people, businesses, or agencies to give personal informatic about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled. Agree to give information about my personal circumstances to my representative. Agree to allow my representative to assign all my rights to medica reimbursement claims to AHCCCS on my behalf.  If I am determined eligible, this authorization will stay in effect until assistance is withdrawn or denied, or when my eligibility ends. Ho adminis	City:	lso ne if ner's
Representative's Mailing Address:  Representative's Phone Number:  Representative's Other Phone Number:  What is the representative's preferred SPOKEN language?  What is the representative's preferred WRITTEN language My representative would like to get information about this a Email:  Yes  No  Email address:  Text:  Yes  No  Number to text (standard text ra  If "Yes" is not marked for Email or Text, all informati  By signing below I, the customer, give permission for the person listed as my representative to act on my behalf in the process of qualifying my  AHCCCS Medical Assistance and/or Medicare Savings Program. I, the  Give permission for my representative to complete and sign my  application.  Give permission to my representative to provide any documents  requested, including personal information.  Give permission to my representative to sign on my behalf to per  other people, businesses, or agencies to give personal information  about me to DES and/or AHCCCS, including protected health  information needed to determine if I am disabled.  Agree to give information about my personal circumstances to my  representative.  Agree to allow my representative to assign all my rights to medica  reimbursement claims to AHCCCS on my behalf.  If I am determined eligible, this authorization will stay in effect until  assistance is withdrawn or denied, or when my eligibility ends. Ho	City:	lso ne if ner's

Transmittal Number: AZ 13-0005-MM

Effective Date: October 1, 2013 Approval Date: September 30, 2013

# PERSON 1:

Tell us about each person in your family starting with you. See page A for a definition of who you must include. If you are a representative, tell us about the first person in the family applying.

Personal Information:			
Name (First, Middle, Last):	Gender:	☐ Male	□ Female
Date of Birth: Social Security Number (optional if not applying):			
Marital Status: ☐ Never Married ☐ Divorced ☐ Widowed ☐ Married-name of spous	e:		
Is PERSON 1 attending school full time? ☐ Yes ☐ No If yes, name of school:			
Is PERSON 1 applying for help with health insurance costs?   Yes No If yes, AHCCCS health in the personal is a personal to the	olan choice:		
Does PERSON 1 need help paying for medical bills	See page D for e		an choices.
from the last 3 months?			
Check here if PERSON 1 only wants help with Medicare costs?   Medicare claim number:			
If PERSON 1 is applying, continue answering the questions below.			
If NOT applying, skip this page and go to the next page to tell us about PERSON 1	s income.		
Citizenship/Residency: Tell us about PERSON 1's citizenship/residency. You may need to provide	proof of citize	nship/resid	lency.
Is PERSON 1 a U.S. citizen or U.S. national? See page B for more information.	Choose not	to answer	
If PERSON 1 is NOT a U.S. citizen, what is his/her immigration status?			
□ Lawful Permanent Resident (LPR) □ Battered Spouse, Child or Parent □ Removal/	Suspension of	Deportation	n
□ Lawful Temporary Resident □ Cuban-Haitian Entrant □ Registry A			
	migrant Juver Protection S		
☐ Refugee ☐ Legalization under LIFE Act ☐ Victim of		iaius (TFS	)
	ng of Deportati	on	
	for Asylum, LF		•
☐ I do not want to provide ☐ Paroled into United States Withhold	ng Deportation	1	
	Visa		
Immigration Document Number: Has PERSON 1 lived in the U.S. since A	Other:	6? □ Ye	es 🗀 No
Did DEDSON 1 mayo to Arizona in the last 4 ma			
Is PERSON 1 an Arizona resident?			
Race (optional), select one or more:	Ethnicity (op		
☐ Asian ☐ Hawaiian or other Pacific Islander ☐ White	☐ Hispanic/	Latino	
☐ Black or African American ☐ American Indian/Alaska Native ☐ Other:	☐ Non-Hisp	anic/Non-L	atino
If PERSON 1 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  □ Yes □ No If yes, name of tri	he:		
is the still still still a local and the still s			
Has he/she ever gotten services from Indian Health Service, ☐ Yes ☐ No If no, is he/she eli	igible? 🔲 Y	'es □ N	0
a tribal health program, or urban Indian health program, or			
through a referral from one of these programs?			
Program Screening: These questions will help determine what programs PERSON 1 may be eligible	e for.		
If PERSON 1 is under the age of 65, does he/she have a mental or physical disability that has kept or will	☐ Yes	□ No	
keep him/her from working for at least 12 months?  If PERSON 1 works and is under the age of 65, does he/she have a disability that is expected to last at	□ Yes	□ No	
least 12 months?	<b>u</b> 163	<b>- 110</b>	
Does PERSON 1 need help with activities of daily living (bathing, dressing, etc.) through personal	☐ Yes	□ No	
assistance, services, nursing home, or other medical facility?			
is PERSON 1 pregnant?	Yes	□ No	
If yes: Number of babies due: Expected due date: Does PERSON 1 live with at least one child under age 19 and is the main care taker of the child?	□ Yes	□ No	
Has PERSON 1 ever received Supplemental Security Income (SSI Cash)?	☐ Yes	□ No	
Additional Questions:			
Is PERSON 1 in jail or prison?  Was PERSON 1 released from jail or prison within the last 4 months?  Yes □ No If yes, releas	e date:		
Was rendered released from Jan or prison within the last 4 months: 165 - 100 m yes, releas	c date.		

Go to the next page to tell us more about PERSON 1.

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Tell us about PERSON 1's expected taxes, income and potential benefits. Complete this page even if PERSON 1 is not applying.

Will PERSON 1 file taxes NEXT YEAR?	☐ Yes	□ No		
If yes, will PERSON 1 file jointly with a spouse?	□ Yes	□ No		If yes, name of spouse:
Will PERSON 1 claim dependents on his/her tax return?	□ Yes	□ No		If yes, name of spouse:  If yes, name of dependent(s):
Will PERSON 1 be claimed as a dependent on someone else's tax return?	□ Yes	□ No		If yes, name of tax filer:
Does PERSON 1 pay any expenses that may be	☐ Alimo	nv		Amount paid: How often?
deducted on the federal income tax return?		nt loan inte	rest	Amount paid: How often? How often?
Do not include self-employment expenses.	Other	deductions		Amount paid: How often?
Check all that apply.	Desc	ribe deduct	tions: _	
Employment: Tell us about PERSON 1's employment. Some current federal tax forms: 1040, SE, and a attach proof of business income and expe	pplicable so	chedules su	uch as ( urrent c	C, C-EZ, E, F and K1. If you do not have tax forms, calendar month.
Does PERSON 1 work?	☐ Yes	□ No	If yes	s, give employment information below:
	Earnings deductions	):	How of	ften paid?  How many hours worked per week?
Is PERSON 1 self-employed?	☐ Yes	□ No	If yes	s, type of work:s, annual net amount:
Does PERSON 1's income change because of contract or	☐ Yes	□ No		s, how much income does PERSON 1 expect to maker the next 12 months?
Seasonal employment?  Other Income: Tell us about other income PERSON 1 re Type of Income:	eceives. Yo		ed to pr	
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension Unemployment			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money    Gaming   Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching,			ed to pr	ovide proof of income.
Type of Income:  Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income:  Social Security benefits  Retirement/pension Unemployment Disability/worker's compensation  Alimony Tribal money			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money			ed to pr	ovide proof of income.
Other Income: Tell us about other income PERSON 1 re Type of Income:  Social Security benefits  Retirement/pension  Unemployment  Disability/worker's compensation  Alimony  Tribal money			ed to pr	ovide proof of income.
Type of Income:  Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money    Gaming   Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income	Amou	nt: Ho	ed to proposed to	ovide proof of income. In received? Who pays the income?
Type of Income:  Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/I	Amou	nt: Ho	ed to proposed to	if PERSON 1 may be eligible for additional benefits.  If yes, employer name:
Type of Income:  Social Security benefits  Retirement/pension  Unemployment Disability/worker's compensation  Alimony  Tribal money	Amou	to help dete	ed to proposed to	if PERSON 1 may be eligible for additional benefits.  If yes, employer name:  If yes, dates of employment:
Type of Income:  Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/I Has PERSON 1 or his/her spouse (living or deceased) eve for a government agency or an employer with a pension pla	Amou	nt: Ho	ed to proposed to	if PERSON 1 may be eligible for additional benefits.  If yes, employer name:  If yes, dates of employment:  If yes, branch of service:
Type of Income:  Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/I Has PERSON 1 or his/her spouse (living or deceased) eve for a government agency or an employer with a pension pla Is PERSON 1 or his/her spouse (living or deceased) a vete	Amou	to help dete	ed to proposed to	if PERSON 1 may be eligible for additional benefits.  If yes, employer name:  If yes, dates of employment:  If yes, branch of service:  If yes, dates of service:
Type of Income:  Social Security benefits  Retirement/pension  Unemployment  Disability/worker's compensation  Alimony  Tribal money    Gaming    Other:  Per capita payments from natural resources, usage rights, leases or royalties  Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land  Money from selling things that have cultural significance  Other:  Other:  Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/lease person place.	Amou	to help dete	ed to proposed to	if PERSON 1 may be eligible for additional benefits  If yes, employer name:  If yes, dates of employment:  If yes, dates of service:  If yes, dates of service:

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

# PERSON 2:

	Tell us about the other	people in y	our family.	See page A for	r a definition of who	vou must include.
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Personal Information:	
	ender: 🗆 Male 🗀 Female
Date of Birth: Social Security Number (optional if not applying):	
Marital Status: ☐ Never Married ☐ Divorced ☐ Widowed ☐ Married-name of spouse:	
Relationship to Person 1:	Other:
Does PERSON 2 live at the same address as Person 1?	
Is PERSON 2 attending school full time?	
Is PERSON 2 applying for help with health insurance costs?   Yes No If yes, AHCCCS health plan ch	oice:
OPTIONAL. See page  Does PERSON 2 need help paying for medical bills	D for enrollment plan choices.
Check here if PERSON 2 only wants help with Medicare costs?   Medicare claim number:	
If PERSON 2 is applying, continue answering the questions below.  If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income	ne.
Citizenship/Residency: Tell us about PERSON 2's citizenship/residency. You may need to provide proof	of citizenship/residency.
Is PERSON 2 a U.S. citizen or U.S. national? See page B for more information. ☐ Yes ☐ No ☐ Choo	ose not to answer
If PERSON 2 is NOT a U.S. citizen, what is his/her immigration status?  Lawful Permanent Resident (LPR) Battered Spouse, Child or Parent Cuban-Haitian Entrant Registry Applic Deferred Action Status Deferred Enforced Departure Refugee Deferred Enforced Departure Refugee Deferred Enforced Departure Deferred Departure Deferred Departure Deferred Enforced Departure Deferred Departure Deferred Enforced Departure Deferred Defe	rant Juvenile Status Applicant otection Status (TPS) ocking Deportation asylum, LPR, TPS, or
☐ I do not want to provide ☐ Paroled into United States Withholding De	eportation
What immigration document does PERSON 2 have? ☐ Permanent Resident card ☐ I-94 ☐ Vis	
Immigration Document Number: Has PERSON 2 lived in the U.S. since Augu	ust 22, 1996? 🗆 Yes 🗅 No
Is PERSON 2 an Arizona resident?	hs? ☐ Yes ☐ No
Race (optional), select one or more:  Asian	Ethnicity (optional):  Hispanic/Latino Non-Hispanic/Non-Latino
If PERSON 2 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  U Yes U No If yes, name of tribe:	« · · · · · · · · · · · · · · · · · · ·
Has he/she ever gotten services from Indian Health Service,	☐ Yes ☐ No
Program Screening: These questions will help determine what programs PERSON 2 may be eligible for.	
If PERSON 2 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	□ Yes □ No
If PERSON 2 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	□ Yes □ No
Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	□Yes □ No
Is PERSON 2 pregnant?  If yes: Number of babies due: Expected due date:	☐ Yes ☐ No
Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child?  Has PERSON 2 ever received Supplemental Security Income (SSI Cash)??	☐ Yes ☐ No ☐ Yes ☐ No
Additional Questions:	
Is PERSON 2 in jail or prison?  Was PERSON 2 released from jail or prison within the last 4 months?  Yes  No  If yes, release date:	
Go to the next page to tell us more about PERSON 2.	

Go to the next page to tell us more about PERSON 2.

M Effective Date: October 1, 2013 A

PERSON 2:				
Tell us about PERSON 2's expected taxes, income and pote	ential benefit	ts. Complete this	s page even if PERSO	N 2 is not applying.
Federal Income Tax Filing: Tell us how PERSON 2	will file incor	me taxes NEXT	ÆAR.	
Will PERSON 2 file taxes NEXT YEAR?	☐ Yes	□ No □		991-91 - 196-91 - 196-91 - 196-91 - 196-91 - 196-91
If yes, will PERSON 2 file jointly with a spouse?	☐ Yes	□ No	If yes, name of spou	use:
Will PERSON 2 claim dependents on his/her tax return?	☐ Yes	□ No	If yes, name of depe	endent(s):
Will PERSON 2 be claimed as a dependent on someone else's tax return?	□ Yes	□ No	If yes, name of tax f Relationship to tax f	iler:
Does PERSON 2 pay any expenses that may be	☐ Alimo	nv	Amount paid:	
deducted on the federal income tax return?		ent loan interest		How often?
Do not include self-employment expenses. Check all that apply.		deductions scribe deductions	Amount paid:	How often?
Commence of the commence of th				male year along ottock the
Employment: Tell us about PERSON 2's employment. most current federal tax forms: 1040, SE,				
forms, attach proof of business income ar				
Does PERSON 2 work?	☐ Yes		es, give employment i	
	Earnings		-there exists	How many hours worked

,					
Does PERSON 2 work?		☐ Yes	□ No	If yes, give employme	ent information below:
Employer's Name and Phone Number:		Earnings deductions	):	How often paid?	How many hours worked per week?
	-				
Is PERSON 2 self-employed?	100	☐ Yes	□ No	If yes, type of work: If yes, annual net amou	unt:
Does PERSON 2's income change because of seasonal employment?	of contract or	☐ Yes	□ No	If yes, how much incon over the next 12 mor	ne does PERSON 2 expect to make hths?

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Alimony			
Tribal money Gaming Other:		,	
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land		-	
Money from selling things that have cultural significance			
Other:			
Other			
Check here if this person does not have income			

Questions for People Under 19 Years Old: This section is	only require	ed if PER	SON 2 is under age 19.
Is PERSON 2 or his/her spouse (living or deceased) a veteran?	□ Yes	□ No	If yes, branch of service:
for a government agency or an employer with a pension plan?	_ 100	_ 110	If yes, dates of employment:
Has PERSON 2 or his/her spouse (living or deceased) ever worked	☐ Yes	☐ No	If yes, employer name:

Questions for reopie officer 13 rears of a. This section is	only require	,	OCITE IS direct age to:
Is PERSON 2's parent (living or deceased) a veteran?	☐ Yes	□ No	If yes, branch of service:
, - , - , - , - , - , - , - , - , - , -			If yes, dates of service:
Does PERSON 2 have a parent living outside the home?	☐ Yes	□ No	

Is there anyone else in PERSON 1's family? If YES, go to the next page to tell us about PERSON 3. If NO, go to page 12.

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PERSON 3: Tell us about the other people in your family. See page A for a definition of who you must include. Personal Information: Name (First, Middle, Last): ☐ Male □ Female Gender: Social Security Number (optional if not applying): Date of Birth: Marital Status: □ Never Married □ Divorced □ Widowed ■ Married-name of spouse: Relationship to Person 1: □ Spouse ☐ Child/Step Child ☐ Parent Other: □ Grandchild □ Niece/Nephew □ Legal Guardian ☐ Yes ☐ No Does PERSON 3 live at the same address as Person 1? If no, what is PERSON 3's home address? Is PERSON 3 attending school full time? □ No If yes, name of school: Is PERSON 3 applying for help with health insurance costs? 

Yes □ No If yes, AHCCCS health plan choice: OPTIONAL. See page D for enrollment plan choices. Does PERSON 3 need help paying for medical bills If yes, what months? Yes □ No from the last 3 months? Check here if PERSON 3 only wants help with Medicare costs? Medicare claim number: If PERSON 3 is applying, continue answering the questions below If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income. Citizenship/Residency: Tell us about PERSON 3's citizenship/residency. You may need to provide proof of citizenship/residency. Is PERSON 3 a U.S. citizen or U.S. national? See page B for more information. ☐ Yes □ No Choose not to answer If PERSON 3 is NOT a U.S. citizen, what is his/her immigration status? ☐ Battered Spouse, Child or Parent □ Lawful Permanent Resident (LPR) □ Removal/Suspension of Deportation □ Lawful Temporary Resident ☐ Cuban-Haitian Entrant □ Registry Applicants □ Deferred Action Status ☐ Special Immigrant Juvenile Status Applicant □ Non-Immigrant Status ☐ Deferred Enforced Departure ☐ Temporary Protection Status (TPS) □ Asylee □ Refugee ☐ Legalization under LIFE Act Victim of Trafficking ☐ Conditional Entrant granted before 1980 ☐ Legalization under IRCA Applicant Withholding of Deportation ☐ Order of Supervision ☐ Applicant for Asylum, LPR, TPS, or Other ☐ Paroled into United States Withholding Deportation ☐ I do not want to provide ☐ Permanent Resident card □ Visa What immigration document does PERSON 3 have? □ I-94 □ Foreign Passport ■ None Other: Immigration Document Number: Has PERSON 3 lived in the U.S. since August 22, 1996? □ Yes □ No Did PERSON 3 move to Arizona in the last 4 months? ☐ Yes ☐ No Is PERSON 3 an Arizona resident? □ Yes □ No If yes, date moved: Race (optional), select one or more: Ethnicity (optional): ☐ Hispanic/Latino □ Asian □ Hawaiian or other Pacific Islander ■ White □ American Indian/Alaska Native Other: ■ Non-Hispanic/Non-Latino ☐ Black or African American If PERSON 3 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe? ☐ Yes ☐ No If yes, name of tribe: Has he/she ever gotten services from Indian Health Service, ☐ Yes If no, is he/she eligible? ☐ Yes ☐ No □ No a tribal health program, or urban Indian health program, or through a referral from one of these programs? **Program Screening:** These questions will help determine what programs PERSON 3 may be eligible for. If PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or will ☐ Yes □ No keep him/her from working for at least 12 months? If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last at □ Yes □ No least 12 months? Does PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal □ Yes ■ No assistance, services, nursing home, or other medical facility? is PERSON 3 pregnant? □ Yes □ No If ves: Number of babies due: Expected due date: Does PERSON 3 live with at least one child under age 19 and is the main care taker of the child? ☐ Yes ☐ No Has PERSON 3 ever received Supplemental Security Income (SSI Cash)? ☐ Yes □ No Additional Questions: Is PERSON 3 in iail or prison? Yes □ No

Go to the next page to tell us more about PERSON 3.

Yes

□ No

If yes, release date:

Was PERSON 3 released from jail or prison within the last 4 months?

PERSON 3:				
Tell us about PERSON 3's expected taxes, income and potential	ential benefit	s. Compl	ete this p	age even if PERSON 3 is not applying.
Federal Income Tax Filing: Tell us how PERSON 3	will file incor	ne taxes N	NEXT YE	AR.
Will PERSON 3 file taxes NEXT YEAR?	☐ Yes	□ No		Annual Control of the
If yes, will PERSON 3 file jointly with a spouse?	☐ Yes	□ No		f yes, name of spouse:
Will PERSON 3 claim dependents on his/her tax return?	☐ Yes	□ No		f yes, name of dependent(s):
Will PERSON 3 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No		f yes, name of tax filer: Relationship to tax filer:
Does PERSON 3 pay any expenses that may be	☐ Alimo			Amount paid: How often?
deducted on the federal income tax return?		nt loan int		Amount paid: How often?
Do not include self-employment expenses.  Check all that apply.		deduction scribe ded		Amount paid: How often?
Employment: Tell us about PERSON 3's employment. most current federal tax forms: 1040, SE, forms, attach proof of business income at	, and applica	ble sched	ules such	as C, C-EZ, E, F and K1. If you do not have
Does PERSON 3 work?	☐ Yes	□ No	If yes	, give employment information below:
	s Earnings		How of	ten paid? How many hours worke
Phone Number: (before	deductions	):		per week?
Is PERSON 3 self-employed?	☐ Yes	□ No		ype of work:
Deep DEDCON 2's income change because of contract or	□ Voo	D No.		annual net amount: now much income does PERSON 3 expect to
Does PERSON 3's income change because of contract or seasonal employment?	☐ Yes	□ No		the next 12 months?
Other Income: Tell us about other income PERSON 3 r	eceives. Yo	u mav nee	ed to prov	ide proof of income.
Type of Income:	Amour			received? Who pays the income?
Social Security benefits				
Retirement/pension				
Unemployment	1		22000000	
Disability/worker's compensation				
Alimony				300000000000000000000000000000000000000
Tribal money Gaming Other:				
Per capita payments from natural resources, usage rights, leases or royalties	BE COMMENT			
Payments from natural resources, farming, ranching,				
fishing, leases or royalties from Indian trust land	ļ			
Money from selling things that have cultural significance				
			A Seem (1992) A See (1992)	
Money from selling things that have cultural significance				
Money from selling things that have cultural significance Other:				
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income		help dete	ermine if F	PERSON 3 may be eligible for additional bene
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h	ner spouse to			
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h Has PERSON 3 or his/her spouse (living or deceased) ever	ner spouse to	help dete	ermine if F	If yes, employer name:
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h Has PERSON 3 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension p	ner spouse to worked plan?	☐ Yes		If yes, employer name: If yes, dates of employment:
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h Has PERSON 3 or his/her spouse (living or deceased) ever	ner spouse to worked plan?		□ No	If yes, employer name:
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h Has PERSON 3 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension p Is PERSON 3 or his/her spouse (living or deceased) a veter	ner spouse to worked plan? ran?	□ Yes	□ No	If yes, employer name:
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h Has PERSON 3 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension p Is PERSON 3 or his/her spouse (living or deceased) a veter  Questions for People Under 19 Years Old: This	ner spouse to worked plan? ran?	□ Yes	□ No	If yes, employer name:  If yes, dates of employment:  If yes, branch of service:  If yes, dates of service:  SON 3 is under age 19.
Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 3 and his/h Has PERSON 3 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension p Is PERSON 3 or his/her spouse (living or deceased) a veter	ner spouse to worked plan? ran?	☐ Yes☐ Yes	□ No □ No ed if PER	If yes, employer name:

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Effective Date: October 1, 2013

# PERSON 4:

Personal Information:					
	ender: 🗆 Male 🖵 Female				
Date of Birth: Social Security Number (optional if not applying):  Marital Status: □ Never Married □ Divorced □ Widowed □ Married-name of spouse:					
Relationship to Person 1:	Other:				
Does PERSON 4 live at the same address as Person 1? ☐ Yes ☐ No If no, what is PERSON 4's home address?					
Is PERSON 4 attending school full time?					
Is PERSON 4 applying for help with health insurance costs?	choice:  D for enrollment plan choices.				
Does PERSON 4 need help paying for medical bills	•				
Check here if PERSON 4 only wants help with Medicare costs?   Medicare claim number:					
If PERSON 4 is applying, continue answering the questions below.  If NOT applying, skip this page and go to the next page to tell us about PERSON 1's incon	me.				
Citizenship/Residency: Tell us about PERSON 4's citizenship/residency. You may need to provide proof	of citizenship/residency.				
	Choose not to answer				
If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?					
	ension of Deportation				
□ Lawful Temporary Resident □ Cuban-Haitian Entrant □ Registry Applic	cants				
<u> </u>	rant Juvenile Status Applicant				
	otection Status (TPS)				
☐ Refugee ☐ Legalization under LIFE Act ☐ Victim of Traffic ☐ Conditional Entrant granted before 1980 ☐ Legalization under IRCA Applicant ☐ Withholding of					
	sylum, LPR, TPS, or				
☐ I do not want to provide ☐ Paroled into United States ☐ Withholding De					
What immigration document does PERSON 4 have? ☐ Permanent Resident card ☐ I-94 ☐ Visa					
☐ Foreign Passport ☐ None ☐ Ott	her:				
☐ Foreign Passport ☐ None ☐ Ott  Immigration Document Number: ☐ Has PERSON 4 lived in the U.S. since Augus    Did PERSON 4 move to Arizona in the last 4 mont	her: st 22, 1996?				
Immigration Document Number:	her:				
Immigration Document Number:  Is PERSON 4 an Arizona resident?  Person Value In the U.S. since August In the U.S. since August In the U.S. since August In the Institute In the U.S. since August In the Institute In the Institute Institut	her: st 22, 1996?				
Immigration Document Number:	her:				
Immigration Document Number:  Is PERSON 4 an Arizona resident?  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  If PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  If PERSON 4 is American lindian or Alaska Native:	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 4 an Arizona resident?  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 an Arizona in the last 4 mont lif yes, date moved:	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 4 an Arizona resident?  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  Is PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  If PERSON 4 move to Arizona in the last 4 mont lif yes, date moved:  If PERSON 4 is American lindian or Alaska Native:	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 4 an Arizona resident?  If yes, date moved:  If yes, date moved:  Is PERSON 4 is American American  Indian or Other Pacific Islander  If PERSON 4 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  Is he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 4 an Arizona resident?  Person Indian or other Pacific Islander  Is Person Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  Is he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?  If Person Indian Indian Person Indian What programs Person I may be eligible for.  If Person Indian Indian Health Program Indian Person Indian Indian Health Program Indian Indian Health Program Indian Indian Health Program Indian Ind	her:  st 22, 1996?				
Immigration Document Number:	her:  st 22, 1996?				
Immigration Document Number:    Has PERSON 4 lived in the U.S. since August	her: st 22, 1996?				
Immigration Document Number:    Secondary   Person   Pers	her: st 22, 1996?				
Immigration Document Number:    Serial Person   Foreign Passport   None   Otto	her: st 22, 1996?				
Immigration Document Number:    Foreign Passport	her: Ist 22, 1996?				
Immigration Document Number:    Foreign Passport   None   Other Has PERSON 4 lived in the U.S. since Augustic Person 4 an Arizona resident?   Yes   No   Did PERSON 4 move to Arizona in the last 4 mont If yes, date moved:    Race (optional), select one or more:   Hawaiian or other Pacific Islander   White   Other:     Asian   Hawaiian or other Pacific Islander   Other:     Black or African American   American Indian/Alaska Native   Other:     If PERSON 4 is American Indian or Alaska Native:   Yes   No   If yes, name of tribe:     Is he/she enrolled in a federally recognized tribe?   Yes   No   If no, is he/she eligible?     Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?    Program Screening: These questions will help determine what programs PERSON 4 may be eligible for.     If PERSON 4 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?     If PERSON 4 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?     Does PERSON 4 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?     If yes: Number of babies due:   Expected due date:     Does PERSON 4 live with at least one child under age 19 and is the main care taker of the child?     Has PERSON 4 ever received Supplemental Security Income (SSI Cash)?	her: st 22, 1996?				
Immigration Document Number:    Foreign Passport	her: Ist 22, 1996?				

Go to the next page to tell us more about PERSON 4.

Do you need help with this application	n? Visit www.healtl	nearizonaplus	agov or call 1-855-HEA-	PLUS (432-7587)		
PERSON 4:						
Tell us about PERSON 4's expected taxes, income and	d potential benefi	ts. Complet	te this page even if PE	RSON 4 is not applying.		
Federal Income Tax Filing: Tell us how PERSO	•	•		44,7.0		
Will PERSON 4 file taxes NEXT YEAR?	☐ Yes	□ No □				
If yes, will PERSON 4 file jointly with a spouse?	☐ Yes	□ No	If yes, name o	f spouse:		
Will PERSON 4 claim dependents on his/her tax return	? 🔲 Yes	□ No		f dependent(s):		
Will PERSON 4 be claimed as a dependent on someor else's tax return?	ne □ Yes	□ No		f tax filer: o tax filer:		
Does PERSON 4 pay any expenses that may be	☐ Alimo	nv		How often?		
deducted on the federal income tax return?		ent loan inte	rest Amount paid:			
Do not include self-employment expenses.		deductions	Amount paid:	How often?		
Check all that apply.	De	scribe dedu	ctions:	part had after the same of the		
Employment: Tell us about PERSON 4's employments current federal tax forms: 1040 forms, attach proof of business incor	, SE, and applicate me and expenses	ble schedul for the last	es such as C, C-EZ, E and current calendar	E, F and K1. If you do not have tax month.		
Does PERSON 4 work?	☐ Yes	□ No	If yes, give employr	ment information below:		
	Gross Earnings fore deductions	):	How often paid?	How many hours worked per week?		
Is PERSON 4 self-employed?	☐ Yes	 □ No	If yes, type of work:			
13 i El 10014 4 dell' ompioyed.	<b>-</b> 100		If yes, annual net am	ount:		
				ount		
Does PERSON 4's income change because of contrac seasonal employment?	tor 🗅 Yes	□No		ome does PERSON 4 expect to make		
seasonal employment?			If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths?		
seasonal employment?  Other Income: Tell us about other income PERSO		u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths?		
seasonal employment?	N 4 receives. Yo	u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths? come.		
Seasonal employment?  Other Income: Tell us about other income PERSO  Type of Income:	N 4 receives. Yo	u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths? come.		
Social Security benefits  Retirement/pension	N 4 receives. Yo	u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths? come.		
Social Security benefits Retirement/pension Unemployment	N 4 receives. Yo	u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths? come.		
Seasonal employment?  Other Income: Tell us about other income PERSO  Type of Income:  Social Security benefits  Retirement/pension  Unemployment  Disability/worker's compensation	N 4 receives. Yo	u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths? come.		
Seasonal employment?  Other Income: Tell us about other income PERSO Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony	N 4 receives. Yo	u may need	If yes, how much inco over the next 12 m	ome does PERSON 4 expect to make onths? come.		
Seasonal employment?  Other Income: Tell us about other income PERSO Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony	N 4 receives. You	u may need	If yes, how much inco over the next 12 m I to provide proof of in	ome does PERSON 4 expect to make onths? come.		
Other Income: Tell us about other income PERSO Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money	N 4 receives. You	u may need	If yes, how much inco over the next 12 m I to provide proof of in	ome does PERSON 4 expect to make onths? come.		
Other Income: Tell us about other income PERSO Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money    Gaming   Other: Per capita payments from natural resources, usage rigleases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land	N 4 receives. You Amount the state of the st	u may need	If yes, how much inco over the next 12 m I to provide proof of in	ome does PERSON 4 expect to make onths? come.		
Other Income: Tell us about other income PERSO Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money    Gaming   Other: Per capita payments from natural resources, usage rigleases or royalties Payments from natural resources, farming, ranching,	N 4 receives. You Amount the state of the st	u may need	If yes, how much inco over the next 12 m I to provide proof of in	ome does PERSON 4 expect to make onths? come.		
Other Income: Tell us about other income PERSO Type of Income: Social Security benefits Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money	N 4 receives. You Amount the state of the st	u may need	If yes, how much inco over the next 12 m I to provide proof of in	ome does PERSON 4 expect to make onths? come.		

Is there anyone else in PERSON 1's family? If YES, go to the next page to tell us about PERSON 5. If NO, go to page 12.

Questions for People Under 19 Years Old: This section is only required if PERSON 4 is under age 19.

☐ Yes

Yes

☐ Yes

Yes

□ No

□ No

☐ No

□ No

If yes, employer name:

If yes, dates of employment: \_

If yes, branch of service: \_ If yes, dates of service: \_\_

If yes, branch of service: If yes, dates of service: \_

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

Has PERSON 4 or his/her spouse (living or deceased) ever worked

for a government agency or an employer with a pension plan?

is PERSON 4 or his/her spouse (living or deceased) a veteran?

Is PERSON 4's parent (living or deceased) a veteran?

Does PERSON 4 have a parent living outside the home?

# PERSON 5:

If there are more than 5 people in your household, make a copy of pages 10 and 11, then tell us about the other people in your household. See page A

for a definition of who you must include.					
Personal Information:					
Name (First, Middle, Last):	ender: 🗅 Male 🗅 Female				
Date of Birth: Social Security Number (optional if not applying):					
Marital Status: ☐ Never Married ☐ Divorced ☐ Widowed ☐ Married-name of spouse:					
Relationship to Person 1:	Other:				
Does PERSON 5 live at the same address as Person 1? ☐ Yes ☐ No If no, what is PERSON 5's home address?					
is PERSON 5 attending school full time?  \( \text{Is No. If we name of school} \)					
Is PERSON 5 applying for help with health insurance costs?   Yes   No If yes, AHCCCS health plan of	choice:				
OPTIONAL. See page  Does PERSON 5 need help paying for medical bills	D for enrollment plan choices.				
Check here if PERSON 5 only wants help with Medicare costs?   Medicare claim number:					
If PERSON 5 is applying, continue answering the questions below.					
If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income	me.				
Citizenship/Residency: Tell us about PERSON 5's citizenship/residency. You may need to provide proof	of citizenship/residency.				
	Choose not to answer				
□ Lawful Temporary Resident □ Cuban-Haitian Entrant □ Registry Applic □ Non-Immigrant Status □ Deferred Action Status □ Special Immigr □ Asylee □ Deferred Enforced Departure □ Temporary Pro □ Legalization under LIFE Act □ Victim of Traffic □ Conditional Entrant granted before 1980 □ Legalization under IRCA Applicant □ Withholding of	rant Juvenile Status Applicant otection Status (TPS) icking Deportation				
	sylum, LPR, TPS, or				
☐ I do not want to provide ☐ Paroled into United States ☐ Withholding Deportation  What immigration document does PERSON 5 have? ☐ Permanent Resident card ☐ I-94 ☐ Visa					
☐ Foreign Passport ☐ None ☐ Ot	her:				
Immigration Document Number:    Foreign Passport	her: ist 22, 1996?				
Foreign Passport	her:				
Immigration Document Number:    Foreign Passport	her: ist 22, 1996?				
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Is PERSON 5 an Arizona resident?  Asian  Is Foreign Passport  Has PERSON 5 lived in the U.S. since Augu  Place (Did PERSON 5 move to Arizona in the last 4 mont of the second of	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Asian  Black or African American    Foreign Passport   None   Ott     Has PERSON 5 lived in the U.S. since Augus     Has PERSON 5 move to Arizona in the last 4 mont     If yes, date moved:   White     American Indian/Alaska Native   Other:	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Person 5 an Arizona resident?  Is Person 5 an Arizona resident?  Is Person 5 an Arizona resident?  Is Person 5 an Arizona in the last 4 month of the second of the	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes No Did PERSON 5 move to Arizona in the last 4 mont If yes, date moved:  Race (optional), select one or more:  Asian Hawaiian or other Pacific Islander White Black or African American American Indian/Alaska Native Other:  If PERSON 5 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	her:  st 22, 1996?				
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Is PERSON 5 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  Is he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine what programs PERSON 5 may be eligible for.  If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or will	her:  st 22, 1996?				
Immigration Document Number:    Has PERSON 5 lived in the U.S. since Augul	her:  Ist 22, 1996?				
Immigration Document Number:	ther:  Ist 22, 1996?				
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Foreign Passport	ther:  Ist 22, 1996?				
Immigration Document Number:    Foreign Passport	ther:  Ist 22, 1996?				
Foreign Passport	ther:  Ist 22, 1996?				
Immigration Document Number:    Has PERSON 5 lived in the U.S. since Augul Is PERSON 5 an Arizona resident?   Yes   No   Did PERSON 5 move to Arizona in the last 4 mont If yes, date moved:    Race (optional), select one or more:   Asian   Hawaiian or other Pacific Islander   White   Other:     Black or African American   American Indian/Alaska Native   Other:     If PERSON 5 is American Indian or Alaska Native:   Is he/she enrolled in a federally recognized tribe?   Yes   No   If yes, name of tribe:     Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?    Program Screening: These questions will help determine what programs PERSON 5 may be eligible for.     If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?     If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?     Does PERSON 5 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?     Is PERSON 5 pregnant?   If yes: Number of babies due:   Expected due date:   Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child?     Has PERSON 5 ever received Supplemental Security Income (SSI Cash)?	ther:  Ist 22, 1996?				

Do you need help with this application? Visi	it www.healthe	arızonaplu	s.gov or ca	all 1-855-HEA-F	PLUS (432-7587)
PERSON 5:					
Tell us about PERSON 5's expected taxes, income and pot	ential benefit	s. Compl	ete this p	age even if Pl	ERSON 5 is not applying.
Federal Income Tax Filing: Tell us how PERSON 5	will file incom	ne taxes N	NEXT YE	AR.	
Will PERSON 5 file taxes NEXT YEAR?	☐ Yes	□ No			en and the second of the secon
If yes, will PERSON 5 file jointly with a spouse?	□ Yes	□ No		If yes, name o	of spouse:
Will PERSON 5 claim dependents on his/her tax return?	☐ Yes	□ No			of dependent(s):
Will PERSON 5 be claimed as a dependent on someone	☐ Yes	□ No	accessor in the rest in the	lf yes, name c	of tax filer:
else's tax return?					o tax filer:
Does PERSON 5 pay any expenses that may be	☐ Alimor			Amount paid:	How often?
deducted on the federal income tax return?	☐ Studer				How often?
Do not include self-employment expenses. Check all that apply.		deduction scribe dec		Amount paid:	How often?
Officer all triat apply.	Des	oribe dec	adelions.		
Employment: Tell us about PERSON 5's employment. most current federal tax forms: 1040, SE forms, attach proof of business income a  Does PERSON 5 work?	, and applicat	ble sched	ules such st and cu	as C, C-EZ, rrent calendar	E, F and K1. If you do not have tax
	s Earnings				How many hours worked
	deductions)	:	How of	ten paid?	per week?
Is PERSON 5 self-employed?	☐ Yes	□ No	If yes,	type of work:	L
				annual net am	
Does PERSON 5's income change because of contract or seasonal employment?	☐ Yes	□ No		how much inc the next 12 m	ome does PERSON 5 expect to make onths?
Other Income: Tall as about other income PERCON 5	raasiraa Var		ad to prov	ido proof of in	
Other Income: Tell us about other income PERSON 5 r					
Type of Income:	Amoun	t: H	ow often	received?	Who pays the income?
Social Security benefits					
Retirement/pension					
Unemployment					
Disability/worker's compensation					
Alimony					
Tribal money Gaming Other:					
Per capita payments from natural resources, usage rights, leases or royalties					= 2211
Payments from natural resources, farming, ranching,					
fishing, leases or royalties from Indian trust land		or Witter Indiana	Mar III a Ma		
Money from selling things that have cultural significance	74o0	**************************************			THE SECTION OF THE SE
Other:	### Common of Ar		SKI SOM I WOOD ON THE SKI		
Other:					
Check here if this person does not have income					
Potential Benefits: Tell us about PERSON 5 and his/h	ner spouse to	help dete	ermine if F	PERSON 5 m	ay be eligible for additional benefits.
Has PERSON 5 or his/her spouse (living or deceased) ever		☐ Yes	□ No		oyer name:
for a government agency or an employer with a pension p					of employment:
Is PERSON 5 or his/her spouse (living or deceased) a vete	ran?	☐ Yes	□ No		ch of service:
				if yes, dates	s of service:
Questions for People Under 19 Years Old: This	s section is o	nly requir	ed if PER	SON 5 is und	er age 19.
Is PERSON 5's parent (living or deceased) a veteran?		☐ Yes	□ No		ch of service:
					s of service:

Go to the next page to tell us about health insurance.

Effective Date: October 1, 2013

☐ Yes

☐ No

Does PERSON 5 have a parent living outside the home?

Health Insurance:						
Answer the following questions for e	veryone applying.					
Health Insurance Coverage:						
Do any applicants have health insura If yes, give the following informati	ance other than AHCCCS or Medicare ion:	?	☐ Yes	□ No		
If yes, give the following information:	Name of Insurance Provider:	Policy	Number:		Coverage E	Effective Date:
A Campaning St		**************************************				
				F 10 1 1 1 1 1 1		
	19 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ACONTAIL.	HELDER THE SECOND SECOND			
Do any applicants have an injury or i	illness due to an accident or medical r	nalpractice?	☐ Yes	□ No	If yes, who	)?
Are any applicants currently admitted			☐ Yes	□ No	If yes, who	
A						
Health Insurance Tax	Credits:					
If you are not eligible for AHCCCS N	fedical Assistance, you may be eligible	e for federal tax	credits to hel	p with yo	ur health ins	surance
premiums. If you are not eligible for Marketplace to see about health insu	any programs through AHCCCS, we urance tax credits.	will send your in	formation to 1	ine redera	ai Heaith ins	surance
Income from John 7 II	al and the state of the state o	formal Alexander a f	. <b>.</b>			
	about health insurance that may be of be coverage offered by an employer, o			☐ Yes	. □ No	☐ I do not know
eligible for coverage in the next 60 d		or will you become	е	u res	i lino	I do not know
If YES, a	answer the questions below. If NO, or	I DO NOT KNO	<b>W</b> go to the	next page	<del>)</del> .	
Tell us about the job that offers healt	th insurance coverage. If there are pla	ans offered by m	ore than one	emplove	r and vou n	eed more space.
please attach additional pages. If yo	ou need help with the information, con	tact the employe	r.			
Employer Name:		Employee So	cial Security	Number: Imber (El	N).	
Employer Address:	City:	Employer ide	State: _	inibol (Li	Zip Code	D:
Who can we contact about employm	ent health insurance coverage at this	job?				
If you are in a waiting or probationar Who is eligible for coverage from this	y period for insurance offered by an e	mployer, when c	an you enrol	l in cover	age?	
	in that meets the minimum value stand	dard*?	,,,,	☐ Yes	□ No	☐ I do not know
If YES: a	answer the questions below. If NO or	I DO NOT KNO	N: go to the	next page	9.	
	the minimum value standard* offered					
If the employer has wellness programs	ms, provide the premium that the emp I did not receive any other discounts b	loyee would pay	if he/she red	eived the	maximum	discount for any
	ive to pay in premiums for that plan?		o programo.			☐ I do not know
How often will the employee ha  ☐ Weekly ☐ Every 2 we		Quarterly	Yearly		not know	☐ Other:
Weekly Every 2 we What changes will the employer make		adatterly C	really	<b>_</b> , ao i	IOI KIIOW	d Other.
☐ Employer will not offer health cove	erage coverage to employees or change the	a promium for the	o lowest-cost	nlan ava	ilable only t	o the employee
that meets the minimum value st	andard*.					o the employee
How much will the employee How often will the employee h	have to pay in premiums for that plan	? \$				☐ I do not know
☐ Weekly ☐ Every 2		☐ Quarterly	□ Yearly	□ld	o not know	Other:
☐ I do not know				- 2/4/4/-		
Renewal of Tax Credit Cove	rage in Future Years:					
To make it easier for the Federal	Facilitated Marketplace to determine	my eligibility for I	nelp paying f	or health	coverage in	future years, I
agree to allow the Marketplace to me make changes, and I can opt	use income data, including information	on from tax return	ns. The Mar	ketplace	will send me	a notice, let
Yes, renew my eligibility for	the next:	3 years	☐ 2 years	□ 1 ye	ar	
	from tax returns to renew my coverage "minimum value standard" if the plan's share of the					

\*An employer-sponsored health plan meets "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Go to the next page to sign the application.

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## Sign the Application:

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf);
   or
- . The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

#### **Penalty Warning**

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

- . You must not knowingly withhold or give false information with the intent to receive or to continue receiving AHCCCS benefits to which you are not entitled.
- You will be required to pay back to AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

#### Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

#### Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my family are approved for AHCCCS benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- · Private or employer-sponsored health insurance (not including Medicare)
- · Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- · Private or employer-sponsored disability insurance
- · Private or employer-sponsored accident insurance
- · Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that AHCCCS cannot collect more than the costs paid by AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

#### Statement of Truth

By signing this application:

- I agree I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

The provided and the same as the same as a same as	
Signature of Applicant:	Date:
Signature of Spouse:	Date:
Signature of Other Adult in Household:	Date:
Signature of Authorized Representative:	Date:
Signature of Witness (if signed with mark):	Date:

# Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

You may give permission to DES and AHCCCS to release information about applicant eligibility. DES and AHCCCS cannot share any information about applicants without the applicant's written permission. This section is OPTIONAL.

Name of Hospital/Hospital's Agent/Org	ganization/Agency:			
Contact Person:		Phone Number:		
Mailing Address:	City:	State:	Zip Code:	
That I have applied for AHCCCS The information or proof needed If approved for AHCCCS Medica	s staff to tell the hospital, hospital agent, organ is Medical Assistance; to see if I can get AHCCCS Medical Assistan al Assistance, the effective date of my eligibility of for AHCCCS Medical Assistance, the reaso	nce; and ty, the redetermination due date,		
Signature of Applicant:		Date:		

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

Attachment 1 Application

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

# Voter Registration:

Tell us if any person over the age of 18 listed on this application would like to register to vote. If yes, we will mail a voter registration form. You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

programs you are engine term			
Would any person on this application over the age of 18 like to register to vote?	□ Yes	□ No	☐ Already registered to vote
If YES is not checked, all persons over the age of 18 on this application will be con	sidered to ha	ve decided i	not to register to vote at this time.
If you believe that someone has interfered with your right to register or to decline to register or your right to choose your own political party or other political p			
State Election Director Secretary of State's Offic 1700 West Washington Phoenix, AZ 85007 602-542-8683			
Phoenix, AZ 85007			

# **Application Checklist:**

Before submitting your application, remember to:

- ☐ Give us your contact information
- Include information about each person in your family
- Sign the application

# Submit the Application:

Submit your completed and signed application along with any supporting documents to your local DES/FAA office.

If any additional information is needed, you will be contacted.

You will be notified of our decision.

Thank you for applying!

Effective Date: October 1, 2013

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)

Arizona Health Care Cost Containment System (AHCCCS)

# **Application for Benefits**

### Tear off and keep pages A through H for your records.

### What is this application for?

Use this application to see if you and members of your household qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- Nutrition Assistance
- Cash Assistance/Temporary Assistance for Needy Families (TANF)
- Tuberculosis Control
- A new tax credit that can help pay your health insurance premiums

See page B for a description of each program.

### Who can use this application?

An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your household members. You can use this application to apply for anyone in your household, even if they already have benefits, including health insurance.

Your household includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance or Cash Assistance)
- People you claim on your income tax return even if they do not live with you
- . Relatives in your care who are under the age of 19 and live with you
- People who you live with that purchase and prepare food with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application.

### Where else can I apply?

You can apply faster online at www.healthearizonaplus.gov.

You can also apply in person at any local Department of Economic Security (DES)/Family Assistance Administration (FAA) office. You can find a list of local FAA offices at www.azdes.gov/faa, or can call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

### What information do I need to complete this application?

For everyone in your household, you may need:

- Birth dates
- Social Security numbers
- Employer and income information for everyone in your household
- Resources (e.g., bank account, cash, property)
- Expenses
- Information for any current health insurance
- Information about any job-related health insurance available to members of your household
- Other information needed to complete your application

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. This will hold your date of application but eligibility <u>cannot</u> be determined until you complete a full application and an interview, if needed.

### Why do we ask for so much information?

We ask about income and other information to make sure you and members of your household get the correct benefits for your household. We will keep all information you provide private, as required by law.

#### What happens next?

Send your completed, signed application to the address on page 21 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

### What if I need help?

If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov Phone: 1-855-HEA-PLUS (432-7587)

In person: Visit www.azdes.gov/faa to find the office closest to you.

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# **Program Information:**

You can use this application to apply for one or more programs. Each program has a symbol. On the application, look for the symbol for the program(s) you want to apply for and answer those questions. These are the symbols you will see on this application:



= Health Insurance Costs (AHCCCS Medical Assistance, Medicare Savings Program, Tax Credits)



= Nutrition Assistance



= Cash Assistance



= Tuberculosis Control

### What is AHCCCS Medical Assistance?



AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona's Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Arizona residents who meet certain income and other eligibility standards.

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication\*
- Doctor's Office Visits\*\*
- Laboratory and X-ray Services
- Hospital Services
- Dialysis

- Medical Supplies
- Medically Necessary Transportation
- · Medically Necessary Specialist Care
- · Behavioral Health Care
- Immunizations (shots)

- Chemotherapy
- Emergency Medical Care
- Rehabilitation Services
- 90 days of nursing care services

- \* AHCCCS prescription coverage is limited for people who have Medicare.
- \*\* Wellness visits for people age 21 and over are not covered.

### What is Medicare Savings Program?



Medicare Savings Program may pay:

- Medicare Part A premium
- Medicare Part B premium
- Medicare deductibles and copayments
- Automatic Extra Help for Medicare Part D prescription expenses

### What are Nutrition Assistance benefits?



Nutrition Assistance benefits help low-income families or individuals buy food for a healthier diet. If you have little or no money, you may be eligible for Emergency Nutrition Assistance benefits. Be sure to answer the Emergency Nutrition Assistance benefits questions on page 2 of this application.

### What is Cash Assistance?



Cash Assistance gives temporary cash benefits to low income families. Parents or relatives of dependent children who are in their care may be eligible. Some families may qualify for a one-time lump sum cash assistance payment. We will determine if you qualify for this payment option.

### What is Tuberculosis Control?



Tuberculosis Control gives cash support to individuals who are determined unable to work by the Department of Health Services as a result of communicable Tuberculosis.

### What if I am not eligible for AHCCCS Medical Assistance?



If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

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Effective Date: October 1, 2013

### How does AHCCCS Medical Assistance work?



If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

- You are American Indian and you choose American Indian Health Program as your health plan.
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States
   Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you
   may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill
   AHCCCS for covered emergency services.

### How much does AHCCCS Medical Assistance cost?



#### Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly
  premium may be able to get it by paying a monthly premium. If you have to pay a premium, the
  premium amounts are \$10 to \$35 per person for employed people with disabilities.

### Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- \$2.30 to \$10.00 for prescriptions
- \$0 to \$30.00 for non-emergency use of an emergency room
- \$3.40 to \$5.00 for outpatient visits for evaluation and management services including doctor's office visits
- \$2.30 to \$3.00 for physical, occupational or speech therapy

Remember to report any changes in income because this may change your co-payment amount.

### The following people are never asked to pay co-payments:

- Children under age 19
- People determined to be Seriously Mentally III (SMI) by the Arizona Department of Health Services
- Individuals through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year
- · People who receive hospice care

### Co-payments are never charged for the following services for anyone:

- Hospitalizations
- Services paid on a fee-for-service basis
- · Emergency services
- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services

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### Do I need a Social Security number?



Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

- If you or anyone you are applying for does not have a Social Security number, we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number. However, it may reduce the total amount of Nutrition Assistance and/or Cash Assistance benefits for the person you are applying for because we will not include you in the benefit amount.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

We use your information, including Social Security number, to:

- · Verify identity
- · Verity citizenship and immigration status
- · Verify income and resources
- · Prevent duplicate benefits
- Establish and enforce child support
- Computer match with state, local and federal agencies and our other programs to verify information
- · Collect money we overpaid you in the form of benefits
- Share with other government agencies and their contractors to assess Nutrition Assistance and/or Cash Assistance program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

## Do I have to give information about my citizenship and immigration status?



- To get the most help, you need to give us information about citizenship and immigration status for each person who is applying for help.
- Giving us the citizenship and immigration status for all people who are eligible for benefits allows us to include them in the Nutrition Assistance and/or Cash Assistance benefit amount. When you do not give us this information, it will not affect the eligibility of the people you are applying for who have given us verification of their citizenship or qualified non-citizen status, but it may affect the amount of the benefits for these people.
- If you choose not to give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying.
- You do need to give us information on income, resources, or other information for those who have not given us citizenship or immigration status information to complete the application process.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for Medical
  Assistance, Nutrition Assistance, and/or Cash Assistance. For those non-citizens, United States
  Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your
  ability to become a Lawful Permanent Resident.
- If you are not applying for any benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS.
- We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family or a household member is in the U.S. illegally.

Effective Date: October 1, 2013

### Will I have to do an interview?



When applying for AHCCCS Medical Assistance and/or help with Medicare costs, an interview is not needed. When applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control you or your representative must complete an interview in person or by phone. If you need special accommodations for an interview, please tell us on page 1 of the application so we can be ready for your interview.

### How long does it take to find out if I am eligible for benefits after you receive my application?



For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 45 days.

- If you are pregnant, we will make a decision within 20 days.
- If you need a disability determination report, we will make a decision within 90 days.



For Nutrition Assistance, we will make a decision within 30 days.

If you are eligible for Emergency Nutrition Assistance, we will make a decision within 7 days.



For Cash Assistance, we will make a decision within 45 days.

• If you are a relative or legal guardian applying only for children who are not your own, we will determine if the children qualify within 20 days.

## How will I know if I am eligible?



- If you are approved for benefits, you will receive a letter explaining the benefits you are eligible for and the amount of benefits you will get.
- If you are denied, we will send you a letter explaining the reason for our decision.

### How can I get my benefits when my application is approved?



If you are approved for AHCCCS Medical Assistance and/or help with Medicare costs, you will get an approval letter. You will get your AHCCCS ID card from your enrollment plan 10 to 14 business days after you get your approval letter. If you need medical services before you get your AHCCCS ID card, contact your enrollment plan.



If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control:

- You will get an Electronic Benefit Transfer (EBT) card. This card works like a debit card. You will get a pamphlet with instructions on how to use your card.
- Your benefits are put on your EBT card after approval. It can take up to 48 hours for the benefits to be available. You can call the Customer Service number on the back of the card to check the balance of your benefits.
- If you are eligible for Emergency Nutrition Assistance, you may get an EBT card at your local DES/FAA
  office.
- If you qualify for Nutrition Assistance benefits, you can use the EBT card to buy approved food items. If you qualify for Cash Assistance benefits, you can use your EBT card to get cash or buy non-food items at any store where EBT cards are accepted. You may also withdraw your Cash Assistance benefits at ATMs, but there may be a fee.

Effective Date: October 1, 2013 Approval Date: September 30, 2013

### What is expected of me?



#### For all programs:

- You must provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize DES and/or AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information for your eligibility.
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report your changes timely.



#### Program-specific expectations:

If applying for help with AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance, you must take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to, Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.



For AHCCCS Medical Assistance and/or Cash Assistance, you must give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.



All adult household members and minor parents who are eligible for Nutrition Assistance and/or Cash Assistance benefits must be fingerprint imaged. Exceptions may apply.

### What are my rights?



### You have the RIGHT to:

- · Courteous and professional treatment.
- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before
  your benefits are reduced or stopped.
- Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or are being reduced, or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
- · Look at your file before a fair hearing.
- · Bring an attorney or any other person to a fair hearing.

To file a discrimination complaint, contact:

USDA, Director Office of Civil Rights Room 326-W, Whitten Building 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410

1-202-720-5964 (voice and TDD)

Attention: Regional Manager U.S. Department of Health and Human Services Office for Civil Rights/Region IX 50 United Nations Plaza, Room 322 San Francisco, CA 94102

1-800-368-1019 (voice) 1-415-437-8311 (TDD)

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Effective Date: October 1, 2013

### What are the Rules and Penalties?



If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:

- Criminal Prosecution
- Fines
- Imprisonment
- Other penalties provided for by state and federal laws

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:

- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise transfer your or someone else's Nutrition Assistance benefits or EBT card.
- Do not buy containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange them for cash or items other than
  eliqible food.
- Do not buy products originally bought with Nutrition Assistance benefits to exchange those products for cash
  or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.
- Do not alter an EBT card.
- Do not use someone else's EBT card unless you are an authorized user approved by DES.

If you knowingly break the rules and get Nutrition Assistance and/or Cash Assistance benefits, we will disqualify you from getting benefits for:

- 12 months for the first violation
- · 24 months for the second violation
- · Permanently for the third violation

You or a household member will not be eligible to get Nutrition Assistance and/or Cash Assistance benefits if you or the household member:

- Is a fleeing felon or probation/parole violator.
- Has been convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.
- Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.
- Has been found by a court of law to have given false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.
- Refuses to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.

You must pay DES back for any Nutrition Assistance and/or Cash Assistance benefits you received for which your household was not eligible. You can make a repayment agreement. If you do not keep your repayment agreement, we may reduce your Nutrition Assistance and/or Cash Assistance benefits, take your income tax refunds, or take other legal action, including taking the amounts from your earnings.

The following additional penalties apply to the Nutrition Assistance Program:

- An additional disqualification, of up to 18 months, may be ordered by a court.
- Any participant or household member who makes false statements or hides information can be fined up to \$250,000.00, imprisoned for up to 20 years, or both.

You and/or your household members may be subject to further prosecution under AZ 13-000-MM

### How to Choose an AHCCCS Health Care Plan:



### You need to choose a health plan that services your county.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS health plan.
- Before you choose a plan, check with your doctor, pharmacy, or hospital to see if they work with the plan that you
  want. If you want more information about the doctors, specialists, or hospitals that work with a health plan that
  serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application.

APACHE COUNTY UnitedHealthcare Community Plan
plans listed under Navajo County.
COCHISE COUNTYUniversity Family Care1-800-582-8686UnitedHealthcare Community Plan1-800-348-4058American Indian Health Program520-295-2479
COCONINO COUNTYUnitedHealthcare Community Plan1-800-348-4058Health Choice Arizona1-800-322-8670American Indian Health Program928-283-2501
If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.
GILA COUNTY         Health Choice Arizona       1-800-322-8670         University Family Care       1-800-582-8686         American Indian Health Program       928-475-2371
GRAHAM COUNTY University Family Care
If your zip code is 85643, you must choose from the health plans listed under Cochise County.
GREENLEE COUNTY University Family Care
LA PAZ COUNTY UnitedHealthcare Community Plan
MARICOPA COUNTY         Health Net of Arizona       1-888-788-4408         Care 1 <sup>st</sup> Arizona       1-866-560-4042         Health Choice Arizona       1-800-322-8670         UnitedHealthcare Community Plan       1-800-348-4058         Mercy Care Plan       1-800-624-3879         Maricopa Health Plan       1-800-582-8686         American Indian Health Program       602-263-1200

MOHAVE COUNTY UnitedHealthcare Community Plan 1-800-348-4058 Health Choice Arizona
If your zip code is 86434, you must choose from the health plans listed under Yavapai County.
NAVAJO COUNTY UnitedHealthcare Community Plan
PIMA COUNTY           UnitedHealthcare Community Plan         1-800-348-4058           Health Choice Arizona         1-800-322-8670           Care 1 <sup>st</sup> Arizona         1-866-560-4042           University Family Care         1-800-582-8686           Mercy Care Plan         1-800-624-3879           American Indian Health Program         520-295-2479
If your zip code is 85645, you must choose from the health plans listed under Santa Cruz County.
PINAL COUNTY           Health Choice Arizona         1-800-322-8670           University Family Care         1-800-582-8686           American Indian Health Program         520-562-3321
If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.
If your zip code is 85292 you must choose from the health plans listed under Gila County.
SANTA CRUZ COUNTY University Family Care
YAVAPAI COUNTY UnitedHealthcare Community Plan
If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.

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If your zip code is 86351 you must choose from the health

plans listed under Coconino County.

YUMA COUNTY

Contact Information:	
Tell us how we can contact an adult member of	your household.
Name (First, Middle, Last):	
Home Address: Apt.	#: City: State: Zip Code:
Mailing Address (if different): Apt.  Do you live in a shelter?	#:City: State:Zip Code:
	☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other:
Other Phone Number: This number is:	□ Home □ Cell □ Work □ Message □ Other:
	☐ Spanish ☐ Other:
What is the preferred WRITTEN household language? ☐ English	n □ Spanish □ Other:
I would like to get information about this application by:	
Email:	ah A
Text:  Yes  No Number to text (standard text rates applied if 'Yes' is not marked for Email or Text, all information for this	application will be sent via U.S. Mail to the mailing address provided.
I need the following help with this application (check all that apply):	
☐ Reading/understanding this application ☐ Filling out this	application
	☐ Language Interpreter Language:
I need the following accommodations for this application (check all ☐ Hearing ☐ Speaking ☐ Seeing ☐ Writing	
Hearing Depearing Deening Devilling	□ Walking □ Other:
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	e someone else to represent you in the application process. DES and/or at your eligibility without your written consent.
AHCCCS cannot release any information about	ut your eligibility without your written consent.
Representative's Name:	ut your eligibility without your written consent.  Is representative your legal guardian?   Yes  No
Representative's Name: Representative's Mailing Address: Representative's Phone Number: This r	ut your eligibility without your written consent.  Is representative your legal guardian? □ Yes □ No City: State: Zip Code: number is: □ Home □ Cell □ Work □ Message □ Other:
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Effective Date: October 1, 2013

## Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

You may give permission to DES and AHCCCS to release information about applicant eligibility. AHCCCS and DES cannot share any information about applicants without the applicant's written permission. This section is OPTIONAL.

Mailing Address:  I give permission for DES  That I have app The information If approved for which I was app Signature of Applicant:  Access to Ele This s may c choos  EBT Representative's Mailes	and/or AHCCCS staff to tell the hospital, lied for AHCCCS Medical Assistance; or proof needed to see if I can get AHCCAHCCCS Medical Assistance, the effective or an experience of the control of the con	hospital agent, organization CCS Medical Assistance; a ve date of my eligibility, the lassistance, the reason I was er (EBT) Accountying for Nutrition Assistance, to get your between the control of the	Standard Sta	ate: / listed abo ation due da Date	Zive: ate, and the cat	p Code:	
I give permission for DES  That I have app The information If approved for A which I was app  Signature of Applicant:  Access to Ele This s may c choos  EBT Representative's March 1 was applicant.	and/or AHCCCS staff to tell the hospital, lied for AHCCCS Medical Assistance; or proof needed to see if I can get AHCCAHCCCS Medical Assistance, the effective order. If denied for AHCCCS Medical ACCAHCCCS Medical ACCAHCCCS Medical ACCAHCAHCAHCAHCAHCAHCAHCAHCAHCAHCAHCAHCA	hospital agent, organization CCS Medical Assistance; a ve date of my eligibility, the lassistance, the reason I was er (EBT) Accountying for Nutrition Assistance, to get your between the control of the	nd edetermina denied.	r listed abo	ve: ate, and the cat	egory of ass	
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may c choos BT Representative's N	hoose a person, called an Alternate e a person you trust. Remember, lo	Cardholder, to get your b		A:			
•		st or stolen benefits will r		r you. If y			
	Name:		EBT R	epresenta	tive's Date of	Birth:	
BT Representative's I	Mailing Address:						
	Phone Number:						
	Other Phone Number:						
•	Suler Friedric Humber.				_		
We off When Econo	en need to contact people or organization we contact these people or organization of the contact these people or organization of the contact information below.	tions we tell them your n	ame, our	title and th	nat we work fo	or the Depa	artment of
ame of someone who	knows you well:		Rela	tionship t	o you:		
ailing Address:		City:			State:	Zip Code	:
ytime Phone Number							
			Rela	ationship 1	to you:		
allina Addrasa.		City					
ailing Address: aytime Phone Number		Oity.			State:	_ Zip Code	:

Go to the next page to tell us about PERSON 1.

## PERSON 1:

Tell us about each person in your household, starting with you. See page A for a definition of who you must include. If you are a representative, tell us about the first person in the household applying.

Personal Information:					
Name (First, Middle, Last):					Gender:
Date of Birth: Social Security Nur	nber (option	al if not a	pplying):		
Marital Status:   Never Marrie			☐ Widowe	d □ Ma	arried-name of spouse:
Is PERSON 1 attending school? ☐ Yes ☐ No Name of School:	If 'Yes	s,' is PER	SON 1 atter Gr	nding schoo ade Level:	ol: ☐ Full Time ☐ Part Time
♣ Is PERSON 1 applying for help with health insurance costs	☐ Yes	□ No	If 'Yes,' Al-	HCCCS hea	alth plan choice:
♣ Is PERSON 1 applying for help with Medicare costs?	□ Yes	□ No	If 'Yes,' M	edicare cla	im number:
Does PERSON 1 need help paying for medical bills from the last 3 months?	□ Yes	□ No			?
Is PERSON 1 applying for Nutrition Assistance?	☐ Yes	☐ No			
\$ Is PERSON 1 applying for Cash Assistance?	□ Yes	□ No			
s PERSON 1 applying for Tuberculosis Control?	☐ Yes	□ No			
If PERSON 1 is applying for If PERSON 1 is <b>NOT</b> applying for					
Citizenship/Residency: Tell us a citizenship/residency.  Is PERSON 1 a U.S. citizen or U.S. national? See page I					
If PERSON 1 is NOT a U.S. citizen, what is his/her immig	ration status	s?			
□ Lawful Permanent Resident (LPR) □ Batte □ Lawful Temporary Resident □ Cuba □ Non-Immigrant Status □ Defe □ Asylee □ Defe □ Refugee □ Lega □ Conditional Entrant granted before 1980 □ Lega □ Other □ Orde	ered Spouse an-Haitian E erred Action erred Enforce alization und alization und er of Supervi oled into Uni	e, Child or Intrant Status ed Depart ler LIFE A ler IRCA ision	ure ct Applicant	☐ Registr☐ Specia☐ Tempo☐ Victim☐ Withho☐ Applica	ral/Suspension of Deportation by Applicants I Immigrant Juvenile Status Applicant by Protection Status (TPS) of Trafficking blding of Deportation ant for Asylum, LPR, TPS, or blding Deportation
What immigration document does PERSON 1 have? ☐ Permanent Resident card ☐ I-94 ☐ Visa ☐ Foreign Passport ☐ None ☐ Other:	lm Ha	migration as PERSC	Document N 1 lived in	Number: _ the U.S. s	since August 22, 1996? ☐ Yes ☐ No
Is PERSON 1 an Arizona resident? ☐ Yes ☐ No		ON 1 mov date mov		a in the last	t 4 months?
Race (optional), select one or more:					Ethnicity (optional):
☐ Asian ☐ Hawaiian or other Pa☐ Black or African American ☐ American Indian/Alas		er 🗆 Wh			☐ Hispanic/Latino☐ Non-Hispanic/Non-Latino☐
If PERSON 1 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?		□ Ye	s 🗆 No	If 'Yes,' r	ame of tribe:
Has he/she ever gotten services from Indian Health Servi health program, or urban Indian health program, or throug from one of these programs?			22000		he/she eligible? ☐ Yes ☐ No
Is he/she living on a reservation?		□ Ye:	s 🗆 No	If 'Yes,' r	ame of reservation:
Tribal Census Number:					

Go to the next page to tell us more about PERSON 1.

		_			-		
		-	$\overline{}$	_		_	
_	_				N	_	
_							

This section asks specific questions for each type of benefit. If PERSON 1 is not applying for any benefits, go to page 5. If PERSON 1 is applying for benefits, complete each applicable section.

PERSON 1	physically or mentally disabled?		Yes	) No			
PERSON	in jail or prison?		☐ Yes ☐	No No			
as PERSO	N 1 released from jail or prison in the last 4 months?		☐ Yes ☐	No If	Yes,' relea	ase dat	e:
•\$	AHCCCS Medical Assistance, Help w Complete this section if PERSON 1 is applying for and/or Cash Assistance.	rith Medicar or help AHCCC	e Costs, S Medical	and Ca Assistanc	sh Assis e and/or h	stanc elp with	e Questions n Medicare costs
PERSON 1	pregnant?		□ Yes				of babies due: I due date:
	is under age 19, are both of his/her parents living in plete the information below:	the home?	□ Yes	□ No			
arent's Nam	e (First, Last):	_ Social Securi	26 <sup>7</sup> :	1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1777267		e of Birth:
ailing Addre	58:	_ City:		State	<b>S</b>	Z	ip Code:
	эг	_ Reason parer	nt is absent:	: D	eceased	□ Oı	ut of home
rent's Nam	e (First, Last):	_ Social Securi	ty Number:	******		Date	e of Birth:
iling Addre	ss:	_ City:		State	ə:	z	ip Code:
	ər:	Reason parer	nt is absent:	: 🗅 D	eceased	□ Ot	ut of home
will keep hii PERSON 1	AHCCCS Medical Assistance and He questions if PERSON 1 is applying for AHCCCS is under the age of 65, does he/she have a mental on/her from working for at least 12 months? works and is under the age of 65, does he/she have	Medical Assist or physical disal	ance and/o pility that ha	r help with is kept or	n Medicare	e costs res	
will keep hir PERSON 1 at least 12 r pes PERSO assistance, pes PERSO	questions if PERSON 1 is applying for AHCCCS is under the age of 65, does he/she have a mental on/her from working for at least 12 months? works and is under the age of 65, does he/she have months?  N 1 need help with activities of daily living (bathing, of services, nursing home, or other medical facility?  N 1 live with at least one child under age 19 and is the	Medical Assist or physical disal a disability that dressing, etc.) the main care ta	ance and/o pility that ha t is expecte hrough pers	r help with as kept or d to last sonal	n Medicare	e costs (es (es (es	
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will keep hin PERSON 1 at least 12 i pes PERSO assistance, pes PERSO ss PERSO as PERSO as PERSO	questions if PERSON 1 is applying for AHCCCS is under the age of 65, does he/she have a mental on/her from working for at least 12 months? works and is under the age of 65, does he/she have months? IN 1 need help with activities of daily living (bathing, of services, nursing home, or other medical facility? IN 1 live with at least one child under age 19 and is the services of Supplemental Security Income (SS Nutrition Assistance and Cash Assistance.	Medical Assister physical disalest a disability that dressing, etc.) the main care tale (Cash)?	ance and/o bility that ha t is expecte hrough per- ker of the c	r help with as kept or d to last sonal child?	Medicare  N  N  Se question t benefits i	e costs fes fes fes fes fes fes fes fes fes fos fes fos fos fos fos fos fos fos fos fos fo	No No No No No No RSON 1 is appe has a felony deconviction:
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will keep hin PERSON 1 at least 12 in Des PERSON assistance, Des PERSON as PERSON as PERSON controlled s as PERSON Cash Assis PERSON 1	questions if PERSON 1 is applying for AHCCCS is under the age of 65, does he/she have a mental on/her from working for at least 12 months? works and is under the age of 65, does he/she have months? N 1 need help with activities of daily living (bathing, of services, nursing home, or other medical facility? N 1 live with at least one child under age 19 and is the services of the services of the services. In the ever received Supplemental Security Income (SS)  Nutrition Assistance and Cash Assist for Nutrition Assistance and/or Cash Assistance conviction. See page G for more information. In the felony conviction for possession, use, or discussion on after August 23, 1996? In the service of	i Medical Assister physical disable or physica	ance and/o collity that ha t is expecte hrough pers ker of the collitions: Ar ay still be a	r help with as kept or d to last sonal shild?	Medicare  Note that the set of th	e costs fes fes fes fes fes fes fes fes fos fes fos fos fos fos fos fos fos fos fos fo	No No No No No No No RSON 1 is appe has a felony deconviction:
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will keep his PERSON 1 at least 12 is oes PERSO assistance, oes PERSO ass PERSON as PERSON controlled s as PERSON 1 PERSON 1 expenses,	questions if PERSON 1 is applying for AHCCCS is under the age of 65, does he/she have a mental on/her from working for at least 12 months? works and is under the age of 65, does he/she have months? N 1 need help with activities of daily living (bathing, of services, nursing home, or other medical facility? N 1 live with at least one child under age 19 and is the service of supplemental Security Income (SS)  Nutrition Assistance and Cash Assist for Nutrition Assistance and/or Cash Assistance conviction. See page G for more information. In that a felony conviction for possession, use, or discussional ance on or after August 23, 1996? In the been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or any fleeing from law enforcement agencies on any chargin violation of probation or parole according to a countric in violation of probation or parole according to a countric in violation of probation or parole according to a countric in violation of probation or parole according to a countric in violation of probation or parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation of parole according to a countric in violation in Arizona or any charging the probation in Arizona or any charging the pr	i Medical Assister physical disable or main care table (Cash)?  Interpretable of the physical disable or p	ance and/o pility that ha t is expecte hrough pers ker of the co tions: Ar hay still be a Yes Yes Yes ons if PERs edical	r help with is kept or do to last sonal child?	se question t benefits i  If 'Yes,' of City/state Type of If 'Yes,' l	e costs fes fes fes fes fes fes fes for convict name convict name convict	No No No No No RSON 1 is appe has a felony deconviction:

Go to the next page to tell us more about PERSON 1.

## PERSON 1:

Tell us about PERSON 1's income, potential benefits and expected tax filing status. Complete this page even if PERSON 1 is not applying for any benefits.



**Employment:** Tell us about PERSON 1's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

the last and current calendar month.				•	roof of business income and expenses to
Does PERSON 1 work?	☐ Yes	□ No	If ye	s, give em	ployment information below:
	s Earnings deductions	s):	How	often paid	How many hours worked per week?
is PERSON 1 self-employed?	ΟY	es 🗅			pe of work:nnual net (after deductions) amount:
If 'Yes,' has PERSON 1 been in this business for 12 mor	nths? 🔲 Y				te business started:
Does PERSON 1's income change because of contract or seasonal employment?	ΟY	es 🗆		make ove	much income does PERSON 1 expect to r the next 12 months?
Does PERSON 1 work in exchange for food or rent?	ΟY	es 🗅	No	If 'Yes,' w	here?
Tell us about other in	come PERS				need to provide proof of income.
Type of Income:	Amount:	How	often re	ceived?	Who pays the income?
Social Security benefits					
Supplemental Security Income (SSI Cash)					
Retirement/pension					
Unemployment					
Disability/worker's compensation					
Child support					
Alimony					
/eterans benefits					
Gifts or loans					
Tribal money Gaming Other:					
Per capita payments from natural resources, usage rights, eases or royalties					
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					
Money from selling things that have cultural significance			No.		Age in the second secon
Other:					
Check here if this person does not have income	0				
Potential Benefits: Tell us about PE Has PERSON 1 or his/her spouse (living or deceased) eve		help det			nay be eligible for additional benefits.
for a government agency or an employer with a pension pla			. Hir		, dates of employment:
Has PERSON 1 or his/her spouse (living or deceased) servilitary?	ved in the	□ Yes	□ No	If 'Yes	,' branch of service:,' dates of service:
If PERSON 1 is under age 19, has his/her parent (living or served in the military?	deceased)	☐ Yes	□ No		,' branch of service:,' dates of service:
Federal Income Tax Filing: Tell u	s how PERS	SON 1 w	ill file inc	ome taxes	NEXT YEAR.
Will PERSON 1 file taxes NEXT YEAR?	□ Yes	□ No	arsa Afrika		
If 'Yes,' will PERSON 1 file jointly with a spouse?	☐ Yes	□ No	and the same of th		name of spouse:
Will PERSON 1 claim dependents on his/her tax return?	☐ Yes	□ No		If 'Yes,'	name of dependent(s):
Nill PERSON 1 be claimed as a dependent on someone else's tax return?	□ Yes	□ No	. 19.32.888		name of tax filer:ship to tax filer:
Does PERSON 1 pay any expenses that may be	☐ Alimo	ny		Amount	paid: How often?
deducted on the federal income tax return?	☐ Stude		\$22222270 h. ' 75" 1110010480	Amount	
Do not include self-employment expenses.  Check all that apply.	☐ Other Desc	deduction oribe dec		Amount	paid: How often?

Is there anyone else in PERSON 1's household? If **YES**, go to the next page to tell us about PERSON 2. If **NO**, go to page 18. Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

PERSON 2:									
Tell us about the other people in	your househol	d. See pa	ige A for a	definition	of who you	u must include.			
Personal Information:									-2-7-1
Name (First, Middle, Last):							Gender:	■ Male	☐ Female
Date of Birth:	Social Secu	irity Numb				D.D			
Relationship to Person 1:	□ Spouse□ Grandchil	d		ild/Step C ece/Neph		☐ Parent ☐ Legal Gua	u Othe ardian	r:	
Marital Status: ☐ Never M		vorced	□ Widow	ed 🗀 I	Married-na	ame of spouse:			
Does PERSON 2 live at the sam If 'No,' what is PERSON 2's he		Person 1?	□ Ye	s 🗆 N	lo				
Is PERSON 2 attending school? Name of school:	☐ Yes ☐	No No	If 'Y€	es,' is PEF		tending school Grade Level:	: 🚨 Full Time	e □ Pai	rt Time
♣ Is PERSON 2 applying for h	elp with health		☐ Yes	□ No	If 'Yes,'	AHCCCS healt	h plan choice:		
insurance costs?  Is PERSON 2 applying for h	•		□ Yes	□ No	OP.	TIONAL. See pa Medicare claim	ge H for enrollm	nent plan o	
costs?  Does PERSON 2 need help	paying for med	dical	□ Yes	□ No		what months?			
bills from the last 3 months?	)			<b>-</b>					
ls PERSON 2 applying for N			☐ Yes	□ No					
\$ Is PERSON 2 applying for C			□ Yes □ Yes	□ No □ No		*			
Is PERSON 2 applying for T	uberculosis Col	ntroi?	u res	□ NO					
						the questions beli about PERSON 2			
Citizenship/re	o/Hesidency sidency.	: Tell us a	about PER	SON 2's c	itizenship/	residency. You	ı may need to	provide p	oroof of
Is PERSON 2 a U.S. citizen or U	J.S. national?	See page I	D for more	informatio	on. 🚨	Yes □ No	☐ Choose no	t to ansv	ver
If PERSON 2 is NOT a U.S. citiz		_							
Lawful Permanent Resident (	LPR)		ed Spouse		d Parent		Suspension of	Deportat	ion
☐ Lawful Temporary Resident☐ Non-Immigrant Status			n-Haitian E red Action			☐ Registry A	pplicants migrant Juven	ile Status	s Applicant
☐ Asylee			red Enforce		ıre	□ Temporary	Protection St		
☐ Refugee	h - f 1000	□ Legali	zation und	er LIFE A	ct	☐ Victim of T			
☐ Conditional Entrant Granted☐ Other	Defore 1980	□ Cegaii	of Supervi	er IHCA A sion	pplicant	☐ Withholdin	g of Deportation or Asylum, LP		or
☐ I do not want to provide			ed into Unit			Withholding [		.,,	
	⊒ I-94 □ Vis	sa				nt Number: I in the U.S. sin	ce August 22,	1996? [	Yes No
☐ Foreign Passport ☐ Is PERSON 2 an Arizona reside			Did PERSO If 'Yes,' d			a in the last 4 r	nonths?	l Yes	□ No
Race (optional), select one or m	ore:					I	nicity (optiona		
	Hawaiian or						Hispanic/Latin		
☐ Black or African American Is he/she enrolled in a federally	American In recognized tribe		a Native	Oth			Non-Hispanic/l e of tribe:	Non-Latir	10
Has he/she ever gotten services health program, or urban Indian from one of these programs?	from Indian He	ealth Servi		□ Yes	□ No	If 'No,' is he/	she eligible?	☐ Yes	□ No
s he/she living on a res	ervation?		nace about the contract of the	☐ Yes	□ No	If 'Yes,' name	e of reservatio	n:	
Tribal Census Number:									

Go to the next page to tell us more about PERSON 2.

ı	D	0	N	9.
		u	IN.	2.

This section asks specific questions for each type of benefit. If PERSON 2 is not applying for any benefits, go to page 8. If PERSON 2 is applying for benefits, complete each applicable section.

s PERSON 2 phy	sically or mentally disabled?		Yes	☐ No			
S PERSON 2 in j			☐ Yes	□ No			
Was PERSON 2 r	released from jail or prison in the last 4 months?		□ Yes	□ No	If 'Yes,' re	elease	date:
<b>+</b> \$	AHCCCS Medical Assistance, Help v Complete this section if PERSON 2 is applying Cash Assistance.						
s PERSON 2 pre	gnant?		□ Yes	□ No			of babies due: ed due date:
	nder age 19, are both of his/her parents living in the e the information below:	home?	□ Yes	□ No		СХРОСК	od dde ddie.
Parent's Name (F	irst, Last):	Social Security	Number:			Dat	e of Birth:
Mailing Address:		City:		Sta	te:	Z	ip Code:
Phone Number: _		leason parent	is absent:		Deceased	<b>0</b> 0	ut of home
		Social Security	Number:			Dat	e of Birth:
Mailing Address:	C	City:		Sta	te:	Z	ip Code:
Phone Number: _	R	leason parent	is absent:		Deceased	□0	ut of home
will keep him/he f PERSON 2 worl at least 12 mont		Assistance an hysical disabil disability that i	d/or help v lity that ha s expecte	with Med is kept or d to last	icare costs	s. Yes Yes	□ No
will keep him/he f PERSON 2 work at least 12 mont Does PERSON 2 assistance, serv	if PERSON 2 is applying for AHCCCS Medical ander the age of 65, does he/she have a mental or per from working for at least 12 months? ks and is under the age of 65, does he/she have a contraction of the she have a co	Assistance an hysical disabil disability that is ssing, etc.) the	d/or help or the distribution in the distribut	with Med is kept or d to last sonal	icare costs	s. Yes	□ No
will keep him/he f PERSON 2 worl at least 12 mont Does PERSON 2 assistance, serv Does PERSON 2	if PERSON 2 is applying for AHCCCS Medical ander the age of 65, does he/she have a mental or per from working for at least 12 months? ks and is under the age of 65, does he/she have a chts?  need help with activities of daily living (bathing, drevices, nursing home, or other medical facility?	Assistance and hysical disabiled disability that is ssing, etc.) the main care taken	d/or help or the distribution in the distribut	with Med is kept or d to last sonal	icare costs	s. Yes Yes Yes	□ No □ No □ No
will keep him/he f PERSON 2 worl at least 12 mont Does PERSON 2 assistance, serv Does PERSON 2 Has PERSON 2 e	if PERSON 2 is applying for AHCCCS Medical ander the age of 65, does he/she have a mental or per from working for at least 12 months? ks and is under the age of 65, does he/she have a oths? need help with activities of daily living (bathing, drevices, nursing home, or other medical facility? live with at least one child under age 19 and is the	Assistance and hysical disability that it assing, etc.) the main care taken ash)?  ance Quest istance. PERSIMATION.	d/or help vilty that has sexpecte rough perser of the c	with Med s kept or d to last sonal hild?  unswer th ay still be	ese questi able to ge	Yes Yes Yes Yes Yes Yes date of co	□ No
will keep him/he f PERSON 2 worl at least 12 mont Does PERSON 2 assistance, serv Does PERSON 2 Has PERSON 2 e  Has PERSON 2 h controlled subst	if PERSON 2 is applying for AHCCCS Medical ander the age of 65, does he/she have a mental or per from working for at least 12 months? ks and is under the age of 65, does he/she have a citis?  need help with activities of daily living (bathing, drevices, nursing home, or other medical facility? live with at least one child under age 19 and is the ever received Supplemental Security Income (SSI Company) for Nutrition Assistance and Cash Assistance applying for Nutrition Assistance and/or Cash Assistance on or after August 23, 1996?	Assistance and hysical disability that it is ssing, etc.) the main care taken ash)?  ance Quest istance. PERSimation. bution of a	d/or help vility that has sexpecte rough person of the continues. A SON 2 magnetic services and services are services and services are services and services are services and services are services are services and services are	with Med s kept or d to last sonal hild?  unswer th ay still be	ese questi able to ge If 'Yes,' of City/stat Type of	Yes Yes Yes Yes Yes Yes date of co convictions	□ No
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will keep him/he f PERSON 2 worl at least 12 mont Does PERSON 2 assistance, serv Does PERSON 2 Has PERSON 2 e  Has PERSON 2 h controlled subst Cash Assistance s PERSON 2 flee PERSON 2 in vi  f PERSON 2 is di expenses, ever	if PERSON 2 is applying for AHCCCS Medical ander the age of 65, does he/she have a mental or per from working for at least 12 months?  ks and is under the age of 65, does he/she have a ciths? need help with activities of daily living (bathing, drevices, nursing home, or other medical facility? live with at least one child under age 19 and is the ever received Supplemental Security Income (SSI CONTITUTE)  Nutrition Assistance and Cash Assistate applying for Nutrition Assistance and/or Cash Assistate applying for Nutrition Assistance and/or Cash Assistate applying conviction. See page G for more informed a felony conviction for possession, use, or distributed a felony conviction for possession, use, or distributed a felony conviction for possession and the felony conviction for possession and felony conviction felony conviction for possession and felony conviction felony convicti	Assistance and hysical disability that is ssing, etc.) the main care taken ash)?  ance Questistance. PERSimation. bution of a state?  and/or her state?  and/or her state?  and or unpaid med or unpaid med or unpaid med	d/or help of lity that has sexpected as expected arough personal representations: A SON 2 mass of the control o	with Med is kept or d to last sonal hild?  Answer th ay still be  No.	ese questi able to ge If 'Yes,' ( City/stat Type of If 'Yes,'	Yes Yes Yes Yes Yes Yes date of co convict name of	□ No

Go to the next page to tell us more about PERSON 2.

If PERSON 2 is under age 19 and is living with his/her parents, are his/her shots current?

☐ Yes

□ No

## PERSON 2:

Tell us about PERSON 2's income, potential benefits and expected tax filing status. Complete this page even if PERSON 2 is not applying for any benefits.



**Employment:** Tell us about PERSON 2's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

the last and current calendar month.							
Does PERSON 2 work?	☐ Yes	□ No	If yes	, give employ	ment inforr	nation below:	
	e deductions		How o	ften paid?	Hov	many hours per week?	
							<del>-</del>
Is PERSON 2 self-employed?		es □ l	No If	'Yes,' type of	f work:		
13 F ENGOIN 2 Self-employed:		63 🗕 1	if	'Yes,' annua	net (after	deductions) an	nount:
If 'Yes,' has PERSON 2 been in this business for 12 me	onths?	′es □ N		'No,' date bu			
Does PERSON 2's income change because of contract o		′es □N	lo If	yes, how muc	ch income	does PERSON	2 expect to
seasonal employment?				nake over the		onths?	•
Does PERSON 2 work in exchange for food or rent?	□ Y	′es □ N	No If	'Yes,' where	?		
Tell us about other	income PERS	SON 2 rec	eives. Y	'ou may need	to provide	proof of incom	ie.
Type of Income:	Amount:	How o	ften rec	eived?	Who	pays the inco	me?
Social Security benefits	be like i						
Supplemental Security Income (SSI Cash)							
Retirement/pension	<b>.</b> 321 1	2.7					
Unemployment	The state of the s		0.52		20.1		
Disability/worker's compensation							
Child support			1000012		wanter and the same of the sam		***************************************
Alimony	1981.46	1 2 2 2					
Veterans benefits					F		
Gifts or loans			4.85				
Tribal money Gaming Other:  Per capita payments from natural resources, usage rights leases or royalties							
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land	- Pandons - Control				-		
Money from selling things that have cultural significance							
Other:							
Check here if this person does not have income	9						
Potential Benefits: Tell us about F Has PERSON 2 or his/her spouse (living or deceased) ev		help dete	rmine if				enefits.
for a government agency or an employer with a pension p		<b>4</b> 168	- U NO	If 'Yes,' da			
Has PERSON 2 or his/her spouse (living or deceased) se military?		□ Yes	□ No	A178 THRESPA ************************************	anch of ser	vice:	
If PERSON 2 is under age 19, has his/her parent (living of served in the military?	r deceased)	☐ Yes	□ No	If 'Yes,' bra			
Federal Income Tax Filing: Tell	us how PER	SON 2 will	I file inco	me taxes NE	XT YEAR.		
Will PERSON 2 file taxes NEXT YEAR?	□ Yes	□ No					nwo
If 'Yes,' will PERSON 2 file jointly with a spouse?	☐ Yes	□ No		If 'Yes,' nam			
Will PERSON 2 claim dependents on his/her tax return?	☐ Yes	□ No				dent(s):	
Will PERSON 2 be claimed as a dependent on someone else's tax return?	□ Yes	□ No		If 'Yes,' nam Relationship			
Does PERSON 2 pay any expenses that may be	☐ Alimo			Amount paid		How often?	
deducted on the federal income tax return?  Do not include self-employment expenses.  Check all that apply.	Other	ent loan in r deduction cribe dedu	ns	Amount paid Amount paid		How often? How often?	

Is there anyone else in PERSON 1's household? If YES, go to the next page to tell us about PERSON 3. If NO, go to page 18.

Approval Date: September 30, 2013

## PERSON 3:

Tell us about the other people in your household. See page A for a definition of who you must include.

+ 🕳 \$ 🗞 Personal Information:							
Name (First, Middle, Last):					Gender:	□ Male	☐ Female
Date of Birth: Social Security Nur	nber (option	al if not ap	plying):				
Relationship to Person 1:	☐ Child	d/Step Chi	ld l	Parent		r:	
Marital Status: ☐ Never Married ☐ Divorced ☐	Widowed	e/Nephew		Legal Guardi of spouse:	an		
Does PERSON 2 live at the same address as Person 1?	□ Yes		eu-name	or spouse.			
If 'No,' what is PERSON 2's home address?					<del></del>	38811. <del></del>	
Is PERSON 3 attending school?	If 'Yes	,' is PERS		nding school : 《 Grade Level:	⊐ Full Tim	e □ Par	t Time
	~	***************************************					
In DEDSON 2 conhing for hole with health	□ Yes	□ No	lf 'Ves ' ΔΙ	HCCCS health p	lan choice		
Is PERSON 3 applying for help with health insurance costs?	<b>□</b> 165	<b>-</b> 140	OPT	IONAL. See page	H for enro	llment plan	choices.
♣ Is PERSON 3 applying for help with Medicare costs?	☐ Yes	□ No		edicare claim nu			
Does PERSON 3 need help paying for medical bills from the last 3 months?	☐ Yes	□ No	If 'Yes,' w	hat months?	<u></u>		
Is PERSON 3 applying for Nutrition Assistance?	□ Yes	□ No					
\$ Is PERSON 3 applying for Cash Assistance?	☐ Yes	☐ No					
LIS PERSON 3 applying for Tuberculosis Control?	☐ Yes	☐ No					
If PERSON 3 is applying fo	r any benefits	: continue a	inswering th	ne questions belov	٧.		
If PERSON 3 is <b>NOT</b> applying for a	ny benefits: g	o to page 1	1 to tell us	about PERSON 3's	s income.		
Citizenship/Residency: Tell us a citizenship/residency.							
Is PERSON 3 a U.S. citizen or U.S. national? See page [			. <u> </u>	es □ No	☐ Choos	e not to ar	nswer
If PERSON 3 is NOT a U.S. citizen, what is his/her immig			Parent	☐ Removal/Su	enoneion	of Donorts	tion
□ Lawful Temporary Resident  □ Cuba	ered Spouse an-Haitian E	ntrant	raieiii	□ Registry App	plicants	•	
_ ;	rred Action rred Enforce		ıre	<ul><li>□ Special Imm</li><li>□ Temporary I</li></ul>			
□ Refugee □ Lega	lization und	er LIFE A	ct	☐ Victim of Tra	afficking	·	0,
	dization und or of Supervi		pplicant	<ul><li>□ Withholding</li><li>□ Applicant for</li></ul>			or
	led into Unit			Withholding			, 01
What immigration document does PEDSON 3 have?	lm	migration l	Document	Number:			
What immigration document does PERSON 3 have?  □ Permanent Resident card □ I-94 □ Visa □ Foreign Passport □ None □ Other:	Ha	s PERSO	N 3 lived in	the U.S. since	August 22	, 1 <b>99</b> 6?(	⊒Yes □ No
Is PERSON 3 an Arizona resident? ☐ Yes ☐ No		ON 3 move date move		a in the last 4 m	onths?	☐ Yes	□ No
Race (optional), select one or more:				Ethn	icity (optio	nal):	
☐ Asian ☐ Hawaiian or other Pa					spanic/La		·
☐ Black or African American ☐ American Indian/Alas  If PERSON 3 is American Indian or Alaska Native:	ska Native	□ Oth	er:	l U N	on-Hispan	ic/Non-Lat	ino
Is he/she enrolled in a federally recognized tribe?		□ Yes	□No	If 'Yes,' name o	of tribe:		
Has he/she ever gotten services from Indian Health Servi health program, or urban Indian health program, or throug from one of these programs?	ce, a tribal gh a referral	□ Yes	□ No	If 'No,' is he/sl	ne eligible	? □Ye	s □ No
\$\ Is he/she living on a reservation?		☐ Yes	□ No	If 'Yes,' name	of reserva	tion:	
Tribal Census Number:	dinire :						
Go to the nex Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona	t page to tel ffective Date:	l us more October 1,	about PEF 2013	RSON 3. Approval	Date: Septe	mber 30, 2	013 Page 9

#		specific questions for each type of benefit. If PE	RSON 3 is not app	lyina fo	r any bene	fits, go to pad	e 11. If PERSON
PERSON 3 physically or mentally disabled?  PERSON 3 in jail or prison?  AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Question Complete this section if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.  PERSON 3 pregnant?  PERSON 3 pregnant?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or IPERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or IPERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a mental or physical disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a mental or physical disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a mental or physical disability that has kept or IPERSON 3 works and is under the age of 65, does he/she have a mental or physical disability				.,	, any some	e, ge te pas	,
PERSON 3 in jall or prison?   Yes   No   If 'Yes,' release date:	<b>⊦</b> ●\$&	Questions for All Applicants: Answer	the following ques	tions if I	PERSON :	3 is applying f	or benefits.
AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Question Complete this section if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.  PERSON 3 pregnant?	PERSON 3 phy	sically or mentally disabled?	C	Yes	□ No		
AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Question Complete this section if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.  PERSON 3 pregnant?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under age 19, are both of his/her parents living in the home?  PERSON 3 is under live;  PERSON 3 is under live;  PERSON 3 is under live;  Social Security Number:  Person is living address:  City:  State:  Zip Code:  No lif 'Yes,' expected due date:  Person is living address:  City:  State:  Zip Code:  No light of living address:  City:  State:  Zip Code:  No light of living address:  City:  Reason parent is absent:  Deceased  Out of home  AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  PERSON 3 is under the age of 56, does he/she have a metal or physical disability that has kept or  will keep him/her from working for at least 12 months?  PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal  at least 12 months?  Does PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal  assistance, services, nursing home, or other medical facility?  Does PERSON 3 live with at least one child under age 19 and is the main care taker of the child?  AND If Yes, date of conviction:  Las PERSON 3 lever received Supplemental Security Income (SSI Cash)?  Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is  applying for Nutrition Assistance and/or Cash Assistance.  PERSON 3 been found to have committed a Nutrition Assistance and/or Cash Assistance.  PERSON 3 been found to have committed a Nutrition Assistance and/or Cash Assistance.  PERSON 3 been found to have committed a Nutrition Assistance and/or Ca							
Complete this section if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.  PERSON 3 pregnant?    Yes	Vas PERSON 3 re	eleased from jail or prison in the last 4 months?		⊒ Yes	□ No	If 'Yes,' releas	se date:
If "Yes," expected due date:	<b> </b> \$	Complete this section if PERSON 3 is applying			sistance a	nd/or help wit	h Medicare costs,
PERSON 3 is under age 19, are both of his/her parents living in the home?	s PERSON 3 preç	gnant?		Yes	□ No II	'Yes,' numbe f 'Yes.' expec	er of babies due: _ ted due date:
Address: City: State: Zip Code: Phone Number: Reason parent is absent: Deceased Out of home Parents Name (First, Last): Social Security Number: Date of Birth: Mailing Address: City: State: Zip Code: Phone Number: Social Security Number: Date of Birth: Mailing Address: City: State: Zip Code: Phone Number: Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Reason parent is absent: Deceased Out of home Parents Name (First, Last): Pa			the home?	Yes			
hone Number:	arent's Name (Fi	rst, Last):				SHOW AS BUILDING	
Parent's Name (First, Last):    Social Security Number:   Date of Birth:	failing Address:		_ City:		State		Zip Code:
Social Security Number:	hone Number: _		Reason parent is	absent:	D De	eceased 🚨	Out of home
AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last works and is under the age of 65, does he/she have a disability that is expected to last works at least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last works at least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last works will be at least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last works will be at least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last works will be a least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have and/or Cash Assistance PERSON 3 may still be able to get benefits if he/she have applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she have felony drug conviction. See page G for more information.  It works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have applying for Nutrition Assistance and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits if he/she have and/or works will be able to get benefits	The second secon		_ Social Security N	umber:			ate of Birth:
AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last will be abled to get be a least 12 months?  If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last will be a least 12 months?  If PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal wassistance, services, nursing home, or other medical facility?  If PERSON 3 live with at least one child under age 19 and is the main care taker of the child?  If Yes No  In Witrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has felony drug conviction. See page G for more information.  It Yes, date of conviction: Controlled substance on or after August 23, 1996?  It Yes, alate of conviction: Type of conviction: Cash Assistance Intentional Program Violation in Arizona or any other state?  It PERSON 3 is disabled or over age 60, does he/she have any paid or unpaid medical was person and the provider, doctor visits, prescriptions, lab work, etc.)?	Mailing Address:		_ City:		State	:	Zip Code:
AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questi if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.    PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or			Reason parent is	absent.		-	-
Does PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  Does PERSON 3 live with at least one child under age 19 and is the main care taker of the child?  Has PERSON 3 ever received Supplemental Security Income (SSI Cash)?  Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has felony drug conviction. See page G for more information.  Has PERSON 3 had a felony conviction for possession, use, or distribution of a			a disability that is	expecte	ed to last	⊔ Yes	⊔ No
Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has felony drug conviction. See page G for more information.  Has PERSON 3 had a felony conviction for possession, use, or distribution of a	Does PERSON 3	need help with activities of daily living (bathing,	dressing, etc.) thro	ugh per	sonal	□ Yes	□ No
Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has felony drug conviction. See page G for more information.  Has PERSON 3 had a felony conviction for possession, use, or distribution of a			the main care taker	of the o	child?	□ Yes	□ No
Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has felony drug conviction. See page G for more information.  Has PERSON 3 had a felony conviction for possession, use, or distribution of a		<u> </u>				☐ Yes	□No
City/state of conviction: Type of conviction:							
Has PERSON 3 been found to have committed a Nutrition Assistance and/or	<b>)</b> \$	applying for Nutrition Assistance and/or Cash	Assistance, PERS				
S PERSON 3 fleeing from law enforcement agencies on any charges, or is PERSON 3 in violation of probation or parole according to a court?  Nutrition Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance (PERSON 3 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?		applying for Nutrition Assistance and/or Cash a felony drug conviction. See page G for more it ad a felony conviction for possession, use, or dis	Assistance. PERSOnformation.	ON 3 m	ay still be	If 'Yes,' date City/state of	of conviction:
f PERSON 3 is disabled or over age 60, does he/she have any paid or unpaid medical Yes No expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	controlled substa	applying for Nutrition Assistance and/or Cash a felony drug conviction. See page G for more it ad a felony conviction for possession, use, or distance on or after August 23, 1996?  Been found to have committed a Nutrition Assistance	Assistance. PERSOnformation. stribution of a name of a n	ON 3 m □ Yes	ay still be □ No	able to get be  If 'Yes,' date  City/state of  Type of con	enefits if he/she has of conviction: conviction: viction:
expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	controlled substantas PERSON 3 books Cash Assistance PERSON 3 flee	applying for Nutrition Assistance and/or Cash a felony drug conviction. See page G for more it ad a felony conviction for possession, use, or distance on or after August 23, 1996?  een found to have committed a Nutrition Assistate Intentional Program Violation in Arizona or anying from law enforcement agencies on any charge	Assistance. PERSO nformation. stribution of a nce and/or other state? ges, or is	ON 3 m □ Yes □ Yes	ay still be	able to get be  If 'Yes,' date  City/state of  Type of con	enefits if he/she has of conviction: conviction: viction:
	controlled substated Has PERSON 3 be Cash Assistance S PERSON 3 flee	applying for Nutrition Assistance and/or Cash a felony drug conviction. See page G for more it ad a felony conviction for possession, use, or distance on or after August 23, 1996?  een found to have committed a Nutrition Assistate Intentional Program Violation in Arizona or anying from law enforcement agencies on any chargolation of probation or parole according to a could	Assistance. PERSOnformation. etribution of a  nce and/or other state? ges, or is rt?	ON 3 m □ Yes □ Yes □ Yes	ay still be  No No	If 'Yes,' date City/state of Type of con If 'Yes,' nan	enefits if he/she had of conviction: conviction: viction: ne of state:
- , - , - , - , - , - , - , - , - , - ,	das PERSON 3 be Cash Assistance S PERSON 3 flee PERSON 3 in view f PERSON 3 is die expenses, even	applying for Nutrition Assistance and/or Cash a felony drug conviction. See page G for more it ad a felony conviction for possession, use, or distance on or after August 23, 1996?  Been found to have committed a Nutrition Assistate Intentional Program Violation in Arizona or any ing from law enforcement agencies on any chargolation of probation or parole according to a countrition Assistance Questions: Ansistance Over age 60, does he/she have any particular in the she has medical insurance (example: travelent)	Assistance. PERSonformation.  Stribution of a name and/or other state?  ges, or is rt?  Swer these question and or unpaid medic	ON 3 m  Yes  Yes  Yes  Yes  Residence of PEI	ay still be  No No	able to get be  If 'Yes,' date City/state of Type of con If 'Yes,' nan  applying for	enefits if he/she has of conviction: conviction: viction: ne of state:

If PERSON 3 is under age 19 and is living with his/her parents, are his/her shots current?

Go to the next page to tell us more about PERSON 3.

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☐ Yes

□ No

## PERSON 3:

Tell us about PERSON 3's income, potential benefits and expected tax filing status. Complete this page even if PERSON 3 is not applying for any benefits.

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***		Ψ	•

**Employment:** Tell us about PERSON 3's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

for the last and current calendar month					
Does PERSON 3 work?	☐ Yes	□ No	If yes,	, give em <sub>l</sub>	ployment information below:
	ss Earnings	۸.	How of	ften paid	? How many hours worked
Phone Number: (befor	e deductions	5):			per week?
			_		
Is PERSON 3 self-employed?	O Y	es 🗆 N	lo If	'Voo ' her	pe of work:
is PERSON 3 self-employed?	<b>-</b> 1	es 🖬 i			nual net (after deductions) amount:
If 'Yes,' has PERSON 3 been in this business for 12 me	onths? QY	es 🗆 N			e business started:
Does PERSON 3's income change because of contract o					much income does PERSON 3 expect to
seasonal employment?					the next 12 months?
Does PERSON 3 work in exchange for food or rent?	ΠY	es 🗆 N	<b>l</b> o If	'Yes,' wh	nere?
Tell us about other	income PERS	ON 3 rec	eives. Y	ou mav n	eed to provide proof of income.
Type of Income:	Amount:		ften rec		Who pays the income?
Social Security benefits					
Supplemental Security Income (SSI Cash)	**************************************	e e e e e e e e e e e e e e e e e e e	San I., 19. 1	Es Eddings (ET.)	5. 機構 19. 大樓 1. 大
Retirement/pension					
Unemployment		5.00		LUMAN MARKET T	EBBHHH25 (, of 4000000 11 17 17 14 14 1
Disability/worker's compensation	94 33372				
Child support ☐ Court ordered ☐ Other:					
Alimony					
Veterans benefits			100		- Youngell And
Gifts or loans					
Tribal money Gaming Other:			7.80		1000 C
Per capita payments from natural resources, usage rights leases or royalties					
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					
Money from selling things that have cultural significance					
Other:					
Check here if this person does not have income	0				
Potential Benefits: Tell us about l					
Has PERSON 3 or his/her spouse (living or deceased) ev		☐ Yes	□ No		' employer name:
for a government agency or an employer with a pension produced Has PERSON 3 or his/her spouse (living or deceased) see		☐ Yes	□ No		' dates of employment: ' branch of service:
military?	ived in the	<b>—</b> 165	<b>—</b> 140		' dates of service:
If PERSON 3 is under age 19, has his/her parent (living of	r deceased)	☐ Yes	□ No		' branch of service:
served in the military?					dates of service:
Federal Income Tax Filing: Tell	us how PERS	SON 3 will	file inco	me taxes	NEXT YEAR.
Will PERSON 3 file taxes NEXT YEAR?	☐ Yes	□ No			
If 'Yes,' will PERSON 3 file jointly with a spouse?	☐ Yes	□ No	nesting	If 'Yes,'	name of spouse:
Will PERSON 3 claim dependents on his/her tax return?	— □ Yes	_ □ No		If 'Yes,' I	name of dependent(s):
Will PERSON 3 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No			name of tax filer:ship to tax filer:ship to tax filer:
Does PERSON 3 pay any expenses that may be	☐ Alimo				paid: How often?
deducted on the federal income tax return?	The second of th	ent loan in	10.00	Amount	
Do not include self-employment expenses.  Check all that apply.	services	deduction cribe dedu		Amount	paid: How often?

Is there anyone else in PERSON 1's household? If YES, go to the next page to tell us about PERSON 4. If NO, go to page 18.

# PERSON 4:

Tell us about the other people in your household. See page A for a definition of who you must include.

Personal Information:	
Name (First, Middle, Last):	Gender: ☐ Male ☐ Female
Date of Birth: Social Security Number (optional	l if not applying):
Relationship to Person 1: Spouse Child/Step Ch	
☐ Grandchild ☐ Niece/Nepher  Marital Status: ☐ Never Married ☐ Divorced ☐ Widowed	w Legal Guardian  ☐ Married-name of spouse:
Does PERSON 2 live at the same address as Person 1? ☐ Yes	□ No
If 'No,' what is PERSON 2's home address?	
Is PERSON 4 attending school? ☐ Yes ☐ No If 'Yes,' Name of School:	is PERSON 4 attending school :   Full Time  Part Time Grade Level:
➡ Is PERSON 4 applying for help with health ☐ Yes ☐ insurance costs?	No If 'Yes,' AHCCCS health plan choice:
_	□ No If 'Yes,' Medicare claim number:
Does PERSON 4 need help paying for medical bills ☐ Yes from the last 3 months?	□ No If 'Yes,' what months?
	⊒ No
\$ Is PERSON 4 applying for Cash Assistance? ☐ Yes ☐	□ No
Is PERSON 4 applying for Tuberculosis Control? □ Yes □	□ No
If PERSON 4 is applying for any benefits: If PERSON 4 is <b>NOT</b> applying for any benefits: go	continue answering the questions below.
ls PERSON 4 a U.S. citizen or U.S. national? See page D for more inf	N 4's citizenship/residency. You may need to provide proof of formation.
If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?	The state of the s
□ Lawful Permanent Resident (LPR) □ Lawful Temporary Resident □ Non-Immigrant Status □ Asylee □ Refugee □ Conditional Entrant granted before 1980 □ Order of Supervise	Child or Parent Intrant Intran
☐ I do not want to provide ☐ Paroled into Unite	ed States Withholding Deportation
	nigration Document Number: PERSON 4 lived in the U.S. since August 22, 1996?
Is BERSON 4 an Arizona resident? Dives Dives Did PERSON	N 4 move to Arizona in the last 4 months? ☐ Yes ☐ No ate moved:
Race (optional), select one or more:	Ethnicity (optional):
☐ Asian ☐ Hawaiian or other Pacific Islander	
☐ Black or African American ☐ American Indian/Alaska Native	☐ Other: ☐ Non-Hispanic/Non-Latino
If PERSON 4 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?	☐ Yes ☐ No If 'Yes,' name of tribe:
Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If 'No,' is he/she eligible? ☐ Yes ☐ No
\$ Is he/she living on a reservation?	☐ Yes ☐ No If 'Yes,' name of reservation:
Tribal Census Number:	

Go to the next page to tell us more about PERSON 4.

DEDCON A

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

		ts: Answer the following questions if PERSON 4 is applying for benefits.
	physically or mentally disabled? in jail or prison?	☐ Yes ☐ No ☐ Yes ☐ No
	V 4 released from jail or prison in the last	
<b>-</b> \$		nce, Help with Medicare Costs, and Cash Assistance Questic 4 is applying for AHCCCS Medical Assistance and/or help with Medicare costs
Is PERSON 4		☐ Yes ☐ No If 'Yes,' number of babies due:
	is under age 19, are both of his/her parer plete the information below:	If 'Yes,' expected due date: ints living in the home? □ Yes □ No
	e (First, Last):	Social Security Number: Date of Birth:
	SS!	City: State: Zip Code:
		Reason parent is absent: Deceased Out of home
	e (First, Last):	Social Security Number: Date of Birth:
	ss:	City:State:Zip Code:
•	er:	Reason parent is absent:    Deceased   Out of home
will keep hi If PERSON 4 at least 12 Does PERSO	m/her from working for at least 12 months works and is under the age of 65, does h months? DN 4 need help with activities of daily livin	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO	m/her from working for at least 12 months works and is under the age of 65, does honths?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO	m/her from working for at least 12 months works and is under the age of 65, does h months? ON 4 need help with activities of daily livin services, nursing home, or other medical	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO Has PERSON Has PERSON	m/her from working for at least 12 months works and is under the age of 65, does honorths?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age N 4 ever received Supplemental Security  Nutrition Assistance and C	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO Has PERSON controlled si Has PERSON	m/her from working for at least 12 months works and is under the age of 65, does honoths?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age N 4 ever received Supplemental Security  Nutrition Assistance and C applying for Nutrition Assistance and felony drug conviction. See page C 4 had a felony conviction for possession ubstance on or after August 23, 1996?	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO Has PERSON controlled si Has PERSON Cash Assists S PERSON 4	m/her from working for at least 12 months works and is under the age of 65, does honorths?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age N 4 ever received Supplemental Security  Nutrition Assistance and C applying for Nutrition Assistance and felony drug conviction. See page C 4 had a felony conviction for possession ubstance on or after August 23, 1996?	he/she have a disability that is expected to last
will keep his If PERSON 4 at least 12 Does PERSO assistance, Does PERSO Has PERSON Controlled si Has PERSON Cash Assist Is PERSON 4 PERSON 4 expenses, medical pro	m/her from working for at least 12 months works and is under the age of 65, does he months?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age N 4 ever received Supplemental Security  Nutrition Assistance and C applying for Nutrition Assistance and felony drug conviction. See page O 4 had a felony conviction for possession ubstance on or after August 23, 1996?  4 been found to have committed a Nutritiance Intentional Program Violation in Ariz fleeing from law enforcement agencies of in violation of probation or parole according Nutrition Assistance Quest is disabled or over age 60, does he/she heven if he/she has medical insurance (exception, doctor visits, prescriptions, lab worked)	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO Has PERSON Controlled si Has PERSON Cash Assist IS PERSON 4 PERSON 4 expenses, medical pro Is PERSON 4	m/her from working for at least 12 months works and is under the age of 65, does he months?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age N 4 ever received Supplemental Security  Nutrition Assistance and C applying for Nutrition Assistance and felony drug conviction. See page O 4 had a felony conviction for possession ubstance on or after August 23, 1996?  14 been found to have committed a Nutritiance Intentional Program Violation in Ariz fleeing from law enforcement agencies of in violation of probation or parole according to the law of	he/she have a disability that is expected to last
will keep hi If PERSON 4 at least 12 Does PERSO assistance, Does PERSO Has PERSON Controlled si Has PERSON 4 PERSON 4 PERSON 4 expenses, medical pro	m/her from working for at least 12 months works and is under the age of 65, does he months?  N 4 need help with activities of daily livin services, nursing home, or other medical N 4 live with at least one child under age N 4 ever received Supplemental Security  Nutrition Assistance and C applying for Nutrition Assistance and felony drug conviction. See page O 4 had a felony conviction for possession ubstance on or after August 23, 1996?  14 been found to have committed a Nutritiance Intentional Program Violation in Ariz fleeing from law enforcement agencies of in violation of probation or parole according to the law of	he/she have a disability that is expected to last

Approval Date: September 30, 2013 Effective Date: October 1, 2013

Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona

## PERSON 4:

Tell us about PERSON 4's income, potential benefits and expected tax filing status. Complete this page even if PERSON 4 is not applying for any benefits.

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**Employment:** Tell us about PERSON 4's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

the last and current calendar month.	-				
Does PERSON 4 work?	☐ Yes	□ No	If yes,	give em	ployment information below:
	Gross Earnings		How of	ten paid	? How many hours worked
Phone Number: (be	fore deductions	):			per week?
In DEDCOM 4 and ampleyed?	□ Y	es 🔲 No	) If	'Von ' hu	pe of work:
Is PERSON 4 self-employed?	<b>-</b>	55 <b>L</b> 140			nual net (after deductions) amount:
If 'Yes,' has PERSON 4 been in this business for 12	months?	es 🗆 No			e business started:
Does PERSON 4's income change because of contract		es 🗆 No			much income does PERSON 4 expect to
seasonal employment?					the next 12 months?
Does PERSON 4 work in exchange for food or rent?	□ Y	es 🗆 No	o If	'Yes,' wh	nere?
Tell us about oth	er income PERS	ON 4 recei	ives. Y	ou may n	eed to provide proof of income.
Type of Income:	Amount:	How of			Who pays the income?
Social Security benefits					
Supplemental Security Income (SSI Cash)		Ed State (Chiasaschio July 1988			
Retirement/pension			5 - 1		
Unemployment					
Disability/worker's compensation					
Child support					
Alimony	TIDS 7546 54				
Veterans benefits					
Gifts or loans					
Tribal money    Gaming    Other:					
Per capita payments from natural resources, usage rig leases or royalties	hts,				
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					
Money from selling things that have cultural significant	e e				
Other:					
Check here if this person does not have income	0				
_					
Potential Benefits: Tell us abo	ut PERSON 4 to	help deterr	nine if I	he/she m	ay be eligible for additional benefits.
Has PERSON 4 or his/her spouse (living or deceased)		☐ Yes	□ No		'employer name:
for a government agency or an employer with a pension	on plan?	<b>—</b> 163			' dates of employment:
Has PERSON 4 or his/her spouse (living or deceased)		☐ Yes	□ No		, branch of service:
military?					' dates of service:
If PERSON 4 is under age 19, has his/her parent (livin	g or deceased)	☐ Yes	☐ No		,' branch of service:
served in the military?				If 'Yes	' dates of service:
Federal Income Tax Filing:	Tell us how PERS	SON 4 will f	ile inco	me taxes	NEXT YEAR.
Will PERSON 4 file taxes NEXT YEAR?	□ Yes	□ No			
If 'Yes,' will PERSON 4 file jointly with a spouse?	☐ Yes	□ No			name of spouse:
Will PERSON 4 claim dependents on his/her tax return	ı? ☐ Yes	□ No	ulle.		name of dependent(s):
Will PERSON 4 be claimed as a dependent on someo else's tax return?	ne 🛚 Yes	□ No			name of tax filer:ship to tax filer:
Does PERSON 4 pay any expenses that may be	□ Alimo			Amount	
deducted on the federal income tax return?		nt loan inte		Amount	
Do not include self-employment expenses.	□ Other	deductions	3	Amount	paid: How often?

Is there anyone else in PERSON 1's household? If YES, go to the next page to tell us about PERSON 5. If NO, go to page 18.

Describe deductions:

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Check all that apply.

	P	П	R	S	0	Ν	5	
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If there are more than 5 people in your household, make a copy of pages 15, 16 and 17, then tell us about the other people in your household. See page A for a definition of who you must include. Attach copied pages to this application.

Personal Information:	e. Attach copied p	ages to this арріпсаціон.
Name (First, Middle, Last):		Gender: ☐ Male ☐ Female
Date of Birth: Social Security Number	(optional if not app	lying):
Relationship to Person 1:	☐ Child/Step Ch ☐ Niece/Nephew	ild Parent Other:
Marital Status: ☐ Never Married ☐ Divorced ☐ Wid		d-name of spouse:
Does PERSON 2 live at the same address as Person 1?	☐ Yes ☐ No	
If 'No,' what is PERSON 2's home address?		
Is PERSON 5 attending school? ☐ Yes ☐ No Name of School:	If 'Yes,' is PERSO	N 5 attending school : ☐ Full Time ☐ Part Time Grade Level:
Harro or osmon		
♣ Is PERSON 5 applying for help with health insurance costs?	es 🗆 No If	'Yes,' AHCCCS health plan choice: OPTIONAL. See page H for enrollment plan choices.
♣ Is PERSON 5 applying for help with Medicare costs? ☐ Y	′es □ No If	'Yes,' Medicare claim number:
♣ Does PERSON 5 need help paying for medical bills □ Y	′es □ No If	'Yes,' what months?
from the last 3 months?  Is PERSON 5 applying for Nutrition Assistance?	′es □ No	
\$ Is PERSON 5 applying for Cash Assistance?		
Is PERSON 5 applying for Tuberculosis Control?     □ Y		
11.0		
If PERSON 5 is applying for any I If PERSON 5 is <b>NOT</b> applying for any ber	benefits: continue an nefits: go to page 17	swering the questions below. to tell us about PERSON 5's income.
Citizenship/Residency: Tell us about citizenship/residency.  Is PERSON 5 a U.S. citizen or U.S. national? See page D for its page D for its page D. S. citizen or U.S. national?		nship/residency. You may need to provide proof of
		Tes and a choose not to answer
If PERSON 5 is NOT a U.S. citizen, what is his/her immigration		arent
	Spouse, Child or Pa aitian Entrant	□ Registry Applicants
gg.	Action Status	☐ Special Immigrant Juvenile Status Applicant ☐ Temporary Protection Status (TPS)
	Enforced Departur on under LIFE Act	☐ Victim of Trafficking
□ Conditional Entrant granted before 1980 □ Legalization	on under IRCA App	
☐ Other ☐ Order of S☐ I do not want to provide ☐ Paroled in	nto United States	Applicant for Asylum, LPR, TPS, or Withholding Deportation
·		
What immigration document does PERSON 5 have?  □ Permanent Resident card □ I-94 □ Visa		ocument Number:
□ Foreign Passport □ None □ Other:	110011	- 100 H 110 0.0. 01100 / 10gust 22, 1000 F 2 100
TO DEDICTING A ARIZONA ROCIDANTY I I VAC I I NO I	PERSON 5 move to 'Yes,' date moved	Arizona in the last 4 months?
Race (optional), select one or more:		Ethnicity (optional):
☐ Asian ☐ Hawaiian or other Pacific I☐ Black or African American ☐ American Indian/Alaska N		
If PERSON 5 is American Indian or Alaska Native:		
Is he/she enrolled in a federally recognized tribe?	☐ Yes	□ No If 'Yes,' name of tribe:
Has he/she ever gotten services from Indian Health Service, a health program, or urban Indian health program, or through a refrom one of these programs?	tribal □ Yes eferral	□ No If 'No,' is he/she eligible? □ Yes □ No
\$ Is he/she living on a reservation?	☐ Yes	□ No If 'Yes,' name of reservation:
Tribal Census Number:		
Go to the next page	e to tell us more at	out PERSON 5

Go to the next page to tell us more about PERSON 5.

SHMM Effective Date: October 1, 2013

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This section asks specific questions for each type of benefit. If PERSON 5 is not applying for any benefits, go to page 17. If PERSON 5 is applying for benefits, complete each applicable section.

TOPO				iv a is apply	ing to belief	110.
	physically or mentally disabled?	□ Ye				
	in jail or prison?	□ Ye		16 ()/2= 1	ologo data	
Was PERSON	5 released from jail or prison in the last 4 months?	□ Ye	s 🖵 No	if Yes, r	elease date:	
<b>+</b> \$	AHCCCS Medical Assistance, Help Complete this section if PERSON 5 is applyin and/or Cash Assistance.					
Is PERSON 5	pregnant?	□ Yes			umber of babi expected due	
	s under age 19, are both of his/her parents living in lete the information below:					
Parent's Name	(First, Last):	_ Social Security Numb	er:		Date of B	irth:
Mailing Addres	S:	City:	St	ate:	Zip Cod	de:
		_ Reason parent is abse	ent: 🚨	Deceased	☐ Out of he	ome
	(First, Last):	_ Social Security Numb	er:		Date of B	irth:
Mailing Addres	s:	_ City:	St	ate:	Zip Cod	de:
Phone Number	:	_ Reason parent is abse	ent: 🚨	Deceased	☐ Out of h	ome
assistance, Does PERSO	Nonths? N 5 need help with activities of daily living (bathing, services, nursing home, or other medical facility? N 5 live with at least one child under age 19 and is 5 ever received Supplemental Security Income (SS)  Nutrition Assistance and Cash Ass applying for Nutrition Assistance and/or Cash felony drug conviction. See page G for more in the security income (SS)	the main care taker of the SI Cash)?  istance Questions Assistance. PERSON 5	ne child?	these ques		OON 5 is
Has PERSON controlled su	5 had a felony conviction for possession, use, or di bstance on or after August 23, 1996?	stribution of a 🔲 Ye	es 🗆 N	City/sta	date of convictions of convictions.	iction: on:
	5 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or any		es 🗆 No		' name of sta	te:
	fleeing from law enforcement agencies on any charn violation of probation or parole according to a cou		es □N	0		Ž.
expenses, e	Nutrition Assistance Questions: Ans s disabled or over age 60, does he/she have any pa ven if he/she has medical insurance (example: trav	aid or unpaid medical			g for Nutrition I Yes □ N	
	ider, doctor visits, prescriptions, lab work, etc.)?			_		
Is PERSON 5	living in an assisted living facility or group home?				l Yes □ N	0
\$	Cash Assistance Questions: Answer Assistance.	this question if PERSO	N 5 is und	er age 19 a		
If PERSON 5 i	s under age 19 and is living with his/her parents, ar	e his/her shots current?			Yes 🗆 N	0

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Go to the next page to tell us more about PERSON 5.

## PERSON 5:

Tell us about PERSON 5's income, potential benefits and expected tax filing status. Complete this page even if PERSON 5 is not applying for any benefits.

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	$\mathbf{\mathcal{L}}$	Ψ	$\sim$

**Employment:** Tell us about PERSON 5's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

the last and current calendar month.				•	•
Does PERSON 5 work?	☐ Yes	□ No	If yes	, give employ	ment information below:
	s Earnings	۸.	How o	ften paid?	How many hours worked
Phone Number: (before	deductions	3):			per week?
Is PERSON 5 self-employed?	□ Y	es 🗆 N		f 'Yes,' type o	
					I net (after deductions) amount:
If 'Yes,' has PERSON 5 been in this business for 12 mor					siness started:
Does PERSON 5's income change because of contract or seasonal employment?	ΠY	es □ No			ch income does PERSON 5 expect to next 12 months?
Does PERSON 5 work in exchange for food or rent?	□ Y	es 🗆 N	o II	f 'Yes,' where	?
Tell us about other in	come PERS	ON 5 rece	ives. Y	ou may need	to provide proof of income.
Type of Income:	Amount:	How of			Who pays the income?
Social Security benefits					THE
Supplemental Security Income (SSI Cash)					
Retirement/pension		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Unemployment					
Disability/worker's compensation					
Child support					x 1887
Alimony	5.111.77				
Veterans benefits	10-A		100000 SAN		44-
Gifts or loans					
Tribal money Gaming Other:			salv inte	STAL UNIVERSIDAD	HM99
Per capita payments from natural resources, usage rights, leases or royalties					
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					
Money from selling things that have cultural significance		Sana V			
Other:					
Check here if this person does not have income					
<b>-</b> ¢					
Potential Benefits: Tell us about PE		help deter	mine if		
Has PERSON 5 or his/her spouse (living or deceased) eve		☐ Yes	□ No		ployer name:
for a government agency or an employer with a pension pla		D Vaa			tes of employment:anch of service:
Has PERSON 5 or his/her spouse (living or deceased) sen military?	ea in the	☐ Yes	□ No		tes of service:
If PERSON 5 is under age 19, has his/her parent (living or	deceased)	☐ Yes	□ No		anch of service:
served in the military?					tes of service:
Federal Income Tax Filing: Tell u			file inco	me taxes NE	XTYEAR.
Will PERSON 5 file taxes NEXT YEAR?	☐ Yes	□ No			
If 'Yes,' will PERSON 5 file jointly with a spouse?	☐ Yes	□ No		A	e of spouse:
Will PERSON 5 claim dependents on his/her tax return?	☐ Yes	□ No		n res, nam	e of dependent(s):
Will PERSON 5 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No		If 'Yes,' nam Relationship	e of tax filer:
Does PERSON 5 pay any expenses that may be	☐ Alimo	nv		Amount paid	warm name of the state of the s
deducted on the federal income tax return?		nt loan inte	erest	Amount paid	How often?
Do not include self-employment expenses.  Check all that apply.		deduction cribe deduc		Amount paid	d:How often?

Is there anyone else in PERSON 1's household? If YES, attach extra pages to tell us about the other people. If NO, go to page 18.

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## **Nutrition Assistance, Cash Assistance and Tuberculosis Control Questions:**

Is anyone in your household applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control? If YES: answer the questions below. If NO: go to the next page.

<b>ბ</b> \$&	Temporary Absence: Tell us about any people who are temporarily living outside of your home that are expected to
ΨΨ	return

Name (First and Last):	Date Left:	Expected Return Date:	Temporary Address:	Why are they out of the home?
				d.

yone in your household is applying for Nutrition  If 'Yes,' total value: \$ Who owns? Name of financial institution:  If 'Yes,' total value: \$ Who owns? Name of financial institution:  If 'Yes,' total value: Who owns? Where?  If 'Yes,' total value: \$ Who owns?	
If 'Yes,' total value: \$	
Who owns? Name of financial institution:  If 'Yes,' total value: \$ Who owns? Name of financial institution:  If 'Yes,' total value: Who owns? Where?  If 'Yes,' total value: \$	
Who owns? Name of financial institution:  If 'Yes,' total value: \$ Who owns? Name of financial institution:  If 'Yes,' total value: Who owns? Where?  If 'Yes,' total value: \$	
If 'Yes,' total value: \$ Who owns? Name of financial institution: If 'Yes,' total value: Who owns? Where? If 'Yes,' total value: \$	
Who owns? Name of financial institution:  If 'Yes,' total value: Who owns? Where?  If 'Yes,' total value: \$	
Name of financial institution:  If 'Yes,' total value:  Who owns?  Where?  If 'Yes,' total value: \$	
If 'Yes,' total value: Who owns? Where? If 'Yes,' total value: \$	
Who owns?	
If 'Yes,' total value: \$	
If 'Yes,' total value: \$	
M/ha ayyaa?	
WALLEY COMPLET	
Who owns?	
If 'Yes,' total value: \$	
How many vehicles?	
If 'Yes,' total value: \$	
Describe resources:	
Who owns?	
If 'Yes,' who?	
What type of benefits?	
When did benefits stop?	
Name of state/county:	
If 'Yes,' who pays?	
Amount paid for care: \$	
How often is care paid for?	
If 'Yes,' amount: \$	
If 'Yes,' who pays?	
Amount paid \$	
How often paid?	
If 'No,' how are you paying your bills?	

Is anyone in your household applying for AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance?

If YES: Go to the next page. If NO: go to page 20.

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Health	Insurance:	p with this application? Visit <u>www.healthearizonaplu</u>	o. 5411	300 1127( ) 2			
<b>+</b> \$	Health Insuran	ce Coverage: Answer the following question		e in your hou	ısehol	ld is applyir	ng for AHCCCS
o any ap		help with Medicare costs, and/or Cash Assista urance other than AHCCCS or Medicare? ation:		Yes 🗅	No		
	ne of Insured:	Name of Insurance Provider:	Р	olicy Numb	er:		Coverage Effective Date:
							Effective Date:
	ALL DOMESTIC						**************************************
T D VIGITO 17		Parallel Plant All Parallel Andrews	-X.1-18				111
							de
		ng questions for everyone applying for AHCCO					
	applicants nave an injury applicants currently adm	or illness due to an accident or medical malpr			No No	If 'Yes,' w	
Ale ally	applicants currently auti	inted to a nospital:		<u> </u>	140	11 103, W	110:
Health	n Insurance Ta	x Credits:					
		CCS Medical Assistance, you may be eligible for	or federal tax	r credits to h	eln w	ith your hea	alth insurance
remiums.		or any programs through AHCCCS, we will ser					
	Insurance fron	<b>Jobs:</b> Tell us about health insurance that m	nay be offere	d through a	job.		
	ne eligible for health insu me eligible for coverage	rance coverage offered by an employer, or wil in the next 60 days?	l you		Yes	□ No	☐ I do not know
		ES: answer the questions below. If NO or I DO					
		nealth insurance coverage. If there are plans obages. If you need help with the information, o			emp	loyer and y	ou need more
							2-d-:
	er Address:	City: oyment health insurance coverage at this job?		State: _		Zip (	Code:
		onary period for insurance offered by an emplo		an you enrol	I in co	verage?	
	eligible for coverage from						
Does the	e employer offer a healtl If <b>Y</b> l	n plan that meets the minimum value standard ES: answer the questions below. If NO or I DO	*? D NOT KNO'		l Yes next	□ No page.	☐ I do not knov
For the		ets the minimum value standard* offered only		•			nlans).
		grams, provide the premium that the employe					
		ams, and did not receive any other discounts t					<b>5</b>
		e have to pay in premiums for that plan? \$ yee have to pay the premium?					_ 🗖 I do not knov
	☐ Weekly ☐ Twice a		Quarterly	□ Yearly		do not knov	V Other:
□ Emple	oyer will not offer health	coverage					
		alth coverage to employees or change the pre	emium for the	lowest-cos	t plan	available o	nly to the
emplo	byee that meets the mini by much will the employ	mum value standard*. ee have to pay in premiums for that plan? \$ _					_ 🗖 I do not know
	How often will the emply	ovee have to pay the premium?					_
□Idon	☐ Weekly ☐ Twice a ot know	month D Every 2 Weeks D Monthly	<b>∟</b> Quaπeny	□ Yeariy	<b>L</b> 10	IO NOL KNOW	u Other:
	Renewal of Ta	x Credit Coverage in Future Years:					

4 years

□ 3 years

☐ 2 years

☐ 1 year

me make changes, and I can opt out at any time.

Yes, renew my eligibility for the next: ☐ 5 years

No, do not use information from tax returns to renew my coverage

<sup>\*</sup>An employer-sponsored health plan meets "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

### Sign the Application:



The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

### **Penalty Warning**

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

- You must not knowingly withhold or give false information with the intent to receive or to continue receiving DES and/or AHCCCS benefits to which you are not entitled.
- You will be required to pay back to DES and/or AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal

#### Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

#### Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- · Private or employer-sponsored health insurance (not including Medicare)
- · Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- · Private or employer-sponsored disability insurance
- · Private or employer-sponsored accident insurance
- · Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that DES and/or AHCCCS cannot collect more than the costs paid by DES and/or AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that DES and/or AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

#### Assignment of Rights to Other Benefits for Cash Assistance

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. I understand:

- While receiving Cash Assistance, the State has the right to keep child support or spousal maintenance collections, including support or spousal maintenance that was owed while Cash Assistance was paid.
- . When Cash Assistance stops, current support payments will be paid to me. The state may continue to collect any assigned back payments for support (assigned arrears) owed before and during the time I received Cash Assistance.
- Child support payments will be used to pay back the state for Cash Assistance paid to me or anyone on my application.
- The State will not keep more from my collected current support or assigned arrears than the total amount of Cash Assistance I received.
- Also the State will not keep any arrears that are more than the total amount of Cash Assistance I received.

#### Statement of Truth

By signing this application:

- I agree I have read and understand the rules and penalties on page G. I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree I have read and understand the assignment of support rights for Cash Assistance above.
- I agree that certain Nutrition Assistance and/or Cash Assistance household members will cooperate with the work programs, which includes looking for work and accepting training and/or a job. If anyone does not, or will not, look for work, attend training, or accept a job, my benefits may be reduced or
- . I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- . In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.
- . If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and becomes a public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

Date:
Date:
Date:
Date:
Date:

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### Voter Registration:

**+**●\$&

Tell us if any person over the age of 18 listed on this application would like to register to vote. If 'Yes,' we will mail a voter registration form.

You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

Would any person on this application over the age of 18 like to register to vote?	Yes	□ No	□ Already registered to vote
---	-----	------	------------------------------

If YES is not checked, all persons over the age of 18 on this application will be considered to have decided not to register to vote at this time.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Election Director Secretary of State's Office 1700 West Washington Phoenix, AZ 85007 602-542-8683

## Submit the Application:



Submit your completed and signed application along with any supporting documents to your local DES/FAA office.

If any additional information is needed, you will be contacted. You will be notified of our decision.

Thank you for applying!

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#### lealth-e-Arizona Online Application Roadmap for Medical Assistance

Note: Arizona's CHIP Program is	Currently	Frozen
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Online Application Page Account Creation - User Agreement Account Creation - About You Home Address Mailing Address User Name and Password	Page Condition	Additional Comment  Identifying Information, email, phone numbers and communication preferences
Account Creation - About You Home Address Mailing Address		
Home Address Mailing Address		
Mailing Address		
Mailing Address		
Secret Questions		
		,
You and the Applying Household		Questions to establish whether the customer is applying for him/herself or his/her family or houesehold or is a representative for another household
Main Contact Information		Identifying information about the primary applicant or representative
Contact Home Address		
Contact Mailing Address		
Other Contact Information		Email and phone numbers
Persons Who Live With You		Establishes who the applicant intends to include
Who is Applying?	This screen will display if there is more than one person listed on the application	Establishes which persons want benefits
Relationships	This screen will display only when there are three or more individuals in the household to define relationships between other applicants.	
Demographic Details		Captures DOB, SSN (optional if not applying
Demographic Details		Captures DOB, SSN, Citizenship, Immigration Status and related information.
Tax Household Information		Collects the primary applicant's tax filing plans, status, and any dependents, including dependents fiving out of the household or whether he/she is a tax dependent (if appropriate)
Tax Household Information	other tay filers in the home	Collects all other persons' tax filing plans, status, and any dependents, including dependents living out of the household or whether each is a tax dependent (if appropriate)
Additional Tax Household Information		Provides the option to supply information about the tax filer, which is necessary for eligibility for APTC
Household Summary		
Temporarily Away From Home		
Race and Ethnicity		
American Indian		
Prior Medical Expenses (Prior Quarter Coverage)		To be implemented for January 2014
Arizona Residency		
SSN Verification Results	This screen will display when one or more persons in the household has a SSN that could not be verified	Allows correction of entries and retry of verification or collection of clarifying information
	This screen will display when one or more persons in the household has Citizenship/Immigration Status that could not	
	Consent to Verify Identity Identity Verification Account Summary Select Programs Notification of Information Use and Privacy You and the Applying Household Main Contact Information Contact Home Address Contact Mailing Address Other Contact Information Persons Who Live With You Who is Applying? Relationships Demographic Details Demographic Details Tax Household Information Tax Household Information Household Summary Temporarily Away From Home Race and Ethnicity American Indian Prior Medical Expenses (Prior Quarter Coverage) Artizona Residency SSN Verification Results Citizenship/Immigration Summary	Consent to Verify Identity Verification Identity Verification Account Summary Select Programs Notification of Information Use and Privacy You and the Applying Household Main Contact Information Contact Home Address Contact Mailing Address This screen will display only when there are three or more individuals in the household to define relationships between other applicants.  This screen will display for persons 18 or older to capture other tax filers in the home Tax Household Information This screen will display for any tax dependent of a filer that he/she does not live with Household Summary Temporarily Away From Home Race and Ethnicity American Indian Prior Medical Expenses (Prior Quarter Coverage) Articona Residency SSN Verification Results This screen will display when one or more persons in the household has a SSN that could not be verified. This screen will display when one or more persons in the household has a SSN that could not be verified.

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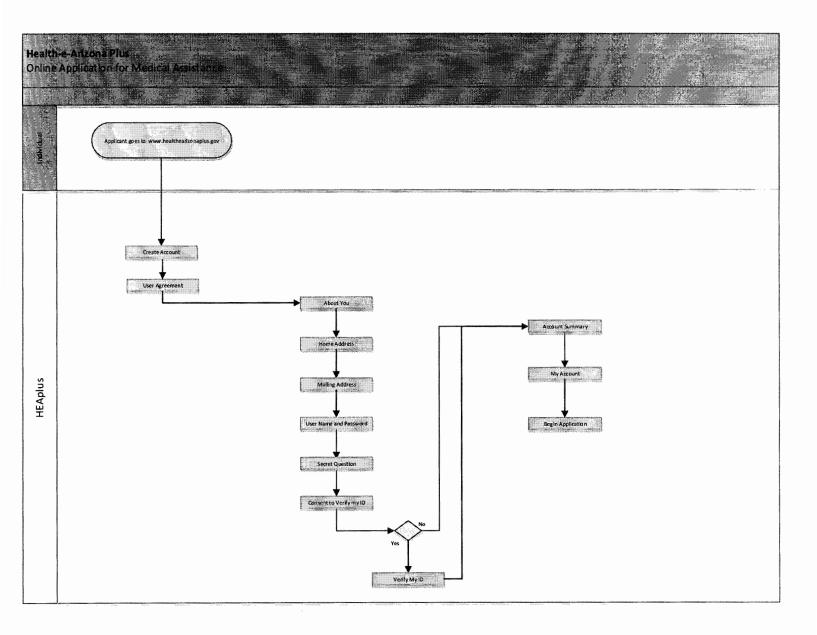
Applying Females (Medical) in the pregnancy range	Pregnancy	This screen will display if there is one or more female	
		applicants between ages 9-60	
	L	This screen will display for if there is one or more applying	
	Tell Us About Parents (Absent Parent(s))	children for whom one or both parents are not in the	
		household	
		This screen will display if there is one or more children with	
	Caretaker Relative	no parents in the application, but one or more adult relative	
		no parents in the application, but one or more addit relative	
Applying Persons	Incarceration		
Applying Persons	Medicare Coverage		
All Persons	Summary of Information Verified and Not Verified		Display of summary as feedback and transition
All Persons	Confirm Income Found From Electronic Sources		
All Persons	Additional Income Information		Collects incidence of income for jobs not found be electronic sources, self employment and other income and determines what additional pages are needed to collect income
All Persons	Rental Income	This screen will display for persons indicated to have Rental Income on the Additional Income Information screen	
All Persons	Self-Employment Income	This screen will display for persons indicated to have self- employment income on the Additional income information	
		screen This screen will display for persons indicated to have income	
40.0		from Franchise, Corporation or LLC on the Additional	
All Persons	Income from Franchises, Corporations or LLC		
		Income Information screen	
***		This screen should only display for persons who selected	
All Persons	Other Income	that they have Other Income on the Income Information	
All Persons	Expected Income Changes	screen	Collects reasonably predictable changes
		This screen will display if the the household that attests to	conces reasonably predictable changes
All Persons	Household Has No Income	having no income	
All Persons	Income Summary		
All Persons apart of the Tax Household	Allowed Deductions From Income	This screen will display if any applying person is not eligible for Medical Assistance at this point. If everyone in the houehold is eligible for Medical Assistance at this point, the system will skip this screen.	
	At this point, the system will know if the applicant(s) are eligible for Medicald based on MAGI. The system may know whether persons are eligible for ABD, Medicald Buy In or Medicare Cost Sharing (IOMS, SUMS, IO.11) For persons that are not yet found eligible, the system will present pages and questions, as appropriate to determine the potential for eligibility in ABD, Medicaid Buy in or Medicare Cost Sharing, Note: Arizona's CHIP program is currently frozen)		
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Unable to Work Due to Disability	This screen will only display for persons who were not already eligible, DO NOT have EARNED income, and are greater than 18 years of age and are not already known to be disabled based on data from electronic sources	Eligibility checked if potential linkage to ABD exists
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Working and Disabled		Eligibility checked if potential linkage to Medicaid Buy In (called Freedom to Work) exists

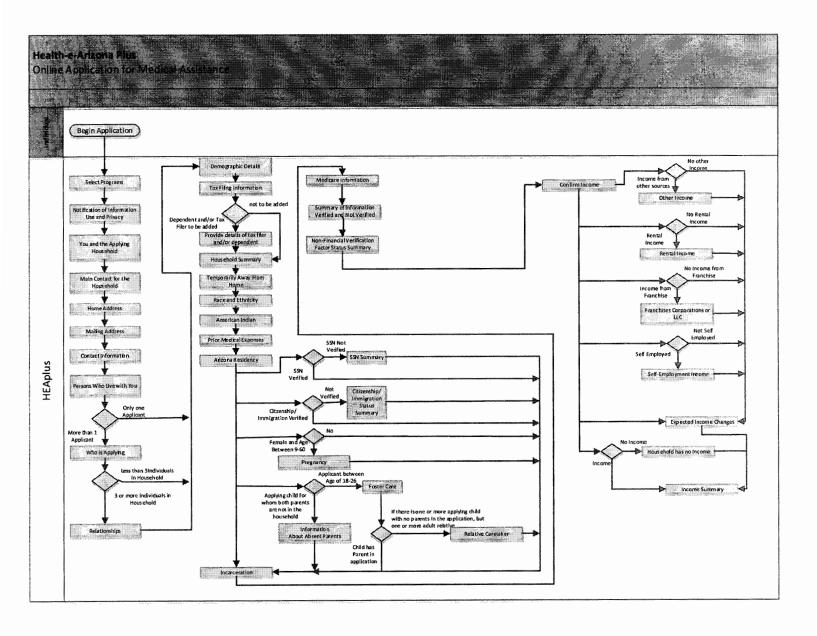
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Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Impairment Related Work Expenses/Blind Related Work Expenses	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare, and are working	Eligibility checked with deductions applied
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Student	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare and are > 22 and have Earned Income	Eligibility checked with appropriate deductions applied
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Child Support	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare	Eligibility for ABD checked with deductions applied
Person(s) eligible or potentially eligible for Medicaid Buy in (Program Called Freedom to Work)	Freedom to Work Premium	This sreen will display for persons who are eligible or potentially eligible for Freedom To Work.	
All Persons	Eligibiity Summary and Information Verified and Not Verified		Display of summary as feedback and transition
	Post Eligibility Questions Required to Complete Application	A Committee of the control of the co	
Persons Eligible or Potentially Eligible for Medicaid	Persons Who Are Inpatient or Have Injury or Illness Due to Malpractice	This sreen will display if there are persons eligible or potentially eligible for Medicaid pending verification.	Question regarding inpatient is required by State Rule to indicate need for expedited processing. It is not necessary if eligibility is successfully completed real-time. Question regarding potential source of TPL applies to any person eligible or potentially eligible for Medicaid
Persons Eligible or Potentially Eligible for Medicaid	Other Health Insurance		
All Persons Eligible or Potentially Eligible for Medicaid or APTC	Insurance Coverage through TRICARE, VA, Peace Corps	This screen should only display for persons who selected that they have insurance on the Insurance Information screen (previous screen)	
Persons Eligible or Potentially Eligible for Medicald	Health Plan Selection	This screen will display if applicants are potentially eligible for a Medicald program	This is an optional question, but is important to the completion of their enrollment and avoid additional contact to obtain their choice.
Applying Persons Potentially Eligible for APTC	Tax Filer Other Information	This screen will display for persons who are potentially APTC eligible and 1) The tax filer who claimed the people didn't provide an SSN 2) People who are potentially eligible for APTC but did not plan to file a tax return or were not indicated as dependents 3) People who are potentially eligible for APTC and ARE married but indicated that they do not plan to file as married filing a joint return.	
Applying Persons Potentially Eligible for APTC	Insurance Coverage through a Job	This screen will display if there is one or more persons potentially APTC eligible	
Applying Persons Potentially Eligible for APTC who entered Other Health Coverage Information on the previous screen	Employer Health Coverage Options	This screen will display for persons who are potentially APTC eligible and who entered Other Health Coverage Information (on the previous screen)	
Applying Persons Potentially Eligible for APTC	Renewal of Coverage in Future Years	This screen will display if there is one or more persons potentially eligible for APTC	
Persons Eligible or Potentially Eligible for Medicald	Other Possible Benefits		Potential for access to pension or veterans administration benefits
	Name an Authorized Representative		
	Rights and Declarations - Signature		
	Eligibility Results with Notices and/or Request for Verification		
	Vote Registration		
	Next Steps		Next Steps as applicable to complete the eligibility and enrollment process or access benefits

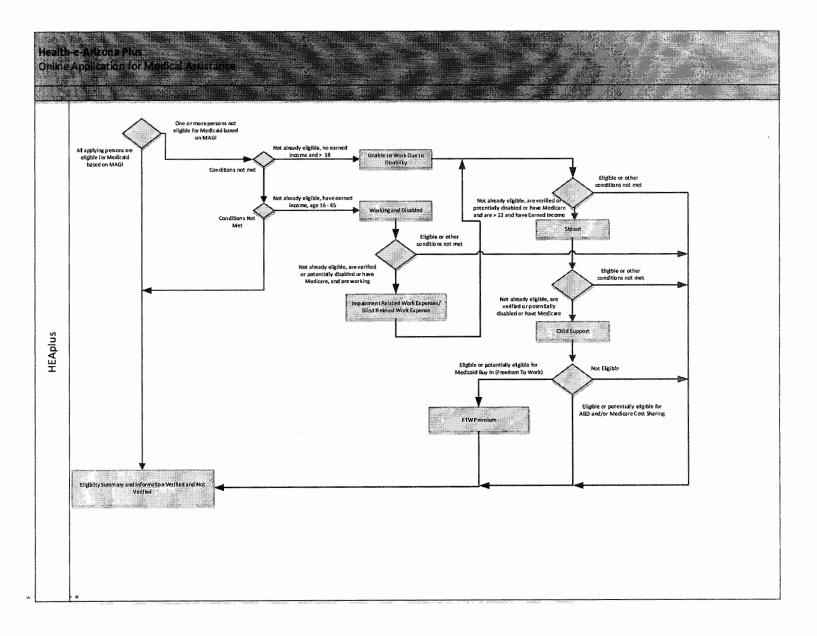
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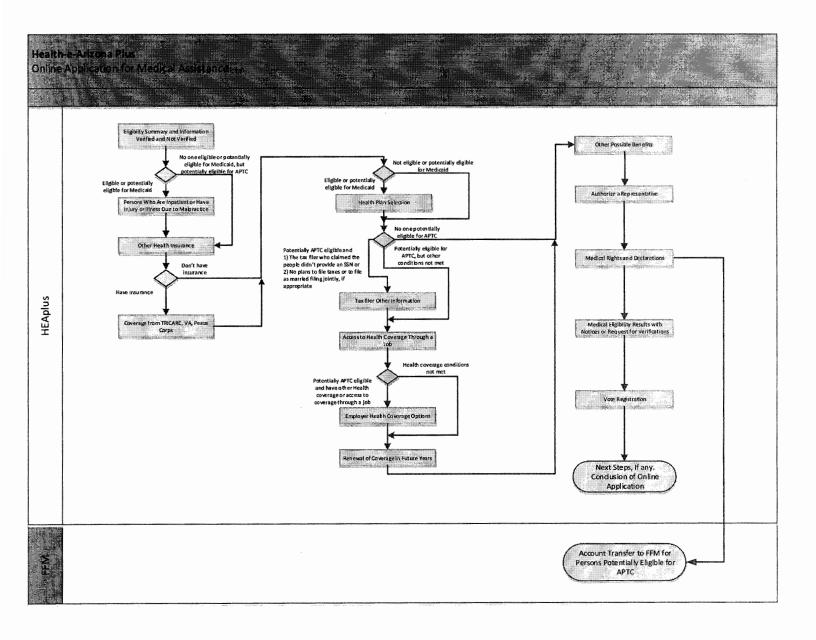




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Attachment 5 Key Differences HEA plus

### Key Differences Between Arizona's Health-e-Arizona Plus Online Application and the CMS Document for the Health Insurance Marketplace Online Application

Health-e-Arizona Plus (www.healthearizonaplus.gov) will be Arizona's integrated online application for Medicaid, CHIP, SNAP, and TANF Cash Assistance.

The Health-e-Arizona Plus online application was compared to the CMS document List of Items in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program, 4/29/2013.

The following questions or data elements are collected on the CMS Health Insurance Marketplace online application, but are not on the Health-e-Arizona Plus online application:

#### **Eligible Immigration Status**

Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use the method outlined on the CMS single streamlined application. Not all legal statuses are Medicaid qualified immigration statuses. Therefore, we have listed the statuses for selection. We also provide the individual with the option to indicate they do not want to provide their immigration status. In this situation the person can only be eligible for emergency services.

#### Potential Disability

Per the CMS document, disability related questions are asked of all applicants to 'screen applicants for the potential for Medicaid eligibility on a basis other than Modified Adjusted Gross Income (MAGI)'. Arizona asks potential disability questions only for those persons not otherwise confirmed to be disabled by electronic data sources and who are not already found eligible on the basis of MAGI.

#### **Expedited Income**

Per the CMS document, Section IX, describes a process 'for tax filers whose income tax data indicates that the household income is above a certain amount so the household doesn't need to answer questions about current/monthly income.' Arizona will not use FTI and does not ask these questions.

#### American Indian/Alaska Native income questions

While income, including tribal income is collected, it is collected along with all other types of income, rather than broken out to a separate series of questions.

#### **Discrepancies**

The CMS document includes 10 questions asked for an person where the electronic income data is not reasonably compatible with the household income attestation. Arizona asks similar conditional questions when, upon reviewing the income data from electronic sources, indicates that the income data is not, or no longer, accurate. These questions and the rules associated with the answers to these questions are integral to Arizona's verification plan and specifically Arizona's rules for reasonable compatibility.

#### **Special Enrollment Periods**

We have not included special enrollment period questions for potential APTC eligible persons. The CMS paper Single Streamlined Application does not include these questions. Guidance also indicates that these are not required for alternative paper or online applications.

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Attachment 5 Key Differences HEA plus

The following questions or data elements are collected on the Health-e-Arizona Plus online application, but are not on the CMS Health Insurance Marketplace online application:

#### **Questions Related to All Medical Assistance Programs**

#### Relationships

We ask for relationships of all persons in relation to other persons, not just in relationship to the primary applicant.

#### **Immigration Status**

Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use the method outlined on the CMS single streamlined application. Not all legal statuses are Medicaid qualified immigration statuses. Therefore, we have listed the statuses for selection. We also provide the individual with the option to indicate they do not want to provide their immigration status. In this situation the person can only be eligible for emergency services.

#### Pregnancy

We ask for the expected due date in order to follow-up when no newborn has been reported by the expected due date.

#### Arizona resident

We ask this question to ensure that the individual considers him/herself a resident of Arizona. We also ask whether any applying person has moved to Arizona in the last month (or in the last four months if prior quarter coverage is needed).

#### **Potential Benefits**

We ask two questions to identify potential benefits for which the individual may be eligible. This includes through access to pension or veterans administration benefits

#### No Income

For households attesting to having 'No Income', we ask questions related how they are meeting their needs. Based on the answers to the questions, they may have income that is considered countable income (e.g., working odd jobs) that they had not previously entered. As indicated in our verification plan, we will perform post eligibility checks of data sources at 6 months to determine if the household is receiving income.

#### Questions Related to Medicaid and CHIP only

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#### Inpatient

Arizona

State rule requires that we determine eligibility expedited timeframe for persons who are inpatient in a hospital inpatient. This question is asked following eligibility determination, but before signature.

Injury or illness due to an accident or medical malpractice

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Attachment 5 Key Differences HEA plus

We ask this question to identify potential sources of third party liability. This question is asked following eligibility determination, but before signature and is a federal requirement to pursue sources of third party liability

#### **Health Plan Choice**

We ask the individuals who are eligible for Medicaid or CHIP, or are eligible pending verification, to indicate their health plan choice. This is an optional question, but is important to the completion of their enrollment and avoid additional contact to obtain their choice. This question is asked following eligibility determination, but before signature.

#### Questions Related to CHIP Only (Note: Arizona's CHIP program enrollment is frozen)

#### Chronic or Serious Illness

If the CHIP program should reopen, we would ask if any CHIP eligible child, that has lost insurance in the last 90 days, has a chronic or serious illness. Arizona waives the 90 day bare period for an eligible child with a chronic or serious illness

#### Questions Related to ABD and Medicaid Buy In (i.e., Freedom to Work (FTW)) Programs

We ask the following questions only as needed for persons identified by data sources to be blind or disabled or otherwise not eligible for Medicaid or CHIP on the basis of MAGI.

#### Past receipt of Supplemental Security Income (SSI Cash)

We ask this question to identify potential eligibility for certain ABD categories.

#### **Potential Disability**

We ask if the person has a mental or physical disability that has or will keep him/her from working for at least 12 months to identify potential eligibility for the Aged, Blind, Disabled (ABD) program.

We ask if the person works and has a significant impairment to identify potential eligibility for the Freedom to Work program.

#### Impairment/Blind Related Work Expenses

We collect eligible expenses only as applicable and needed to complete the eligibility determination

#### Student Earned Income Exclusion

We collect student status for persons under age 22, disabled or potentially disabled, and having earned income, and otherwise over income for these programs in order to apply the student earned income exclusion.

#### Court-Ordered Child Support

We collect court-order child support for parents of a disabled or potentially disabled person who is otherwise over income for these programs, in order to apply the child support deduction

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